सत्यमेव जयते

Health Sector Reforms in India

Initiatives From Nine States

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AUGUST 2004

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In collaboration with

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(Addl. Economic Adviser)

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Individuals who have contributed to the development of this document

Introduction

INTRODUCTION

Health Sector Reforms have been the subject of increasing attention and is an often-used word in the health parlance today. The last two decades have seen health sector reforms emerge as a major issue on the policy agenda. Despite different levels of income, institutional structures, and historical experiences, many countries in recent years, have embarked on health sector reform in varying degrees. A wide range of contextual factors including the changing health scenario, macroeconomic situation, political environment, societal values, dwindling resources and external influences affect the development of health sector reform in a particular country. While the term 'reform' has become increasingly popular during the last few years, there is no consistent and universally accepted definition of what constitutes health sector reform thereby leading to varied meanings and connotations.

Berman[1] describes health sector reform as 'sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector' while Cassels[2] states that health care reform is concerned with 'defining priorities, refining policies and reforming the institutions through which those policies are implemented' *(Cassels, 1995 cited in Figueras J et al, 1997).* Health sector reform is also defined as 'a sustained process of fundamental change in policy and institutional arrangements of the health sector, usually guided by the government. The process lays down a set of policy measures covering the four main core functions of the health system, viz. governance, provision, financing and resource generation. It is designed to improve the functioning and performance of the health sector and ultimately the health status of the people.' *(WHO[3])* To sum, health sector reform is deliberate, planned and intended to make long term, permanent changes, rather than ad hoc or emergency action. It is about seeking solutions to major problems in a country's health care system and involves many actors, institutions and stakeholders. While most of the health sector problems that reformers identify tend to be relatively 'technical', solutions require much more than developing or applying the 'right' technical answer. Designing and implementing health sector reform is a preeminently political process. Hence, health sector reform deals with equity, efficiency, quality, financing and sustainability in the provision of health care and also in defining the priorities, refining the policies, and reforming the institutions through which policies are implemented. It is a process of change involving the what, who and how of health sector action, and generally forms part of a bigger reform taking place in the public sector *(WHO[4]).*

The content of reforms is a complex process. There is no universal 'package' of measures, which would constitute health sector reforms, and reforms have tended to assume varied forms across various countries. One of the approaches adopted by Thomason[5] for classifying reforms is:

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[1] Berman, Peter (1995), Health Sector Reform: Making Health Development Sustainable in Peter Berman, ed. *Health Sector Reform in Developing Countries: Making Health Development Sustainable.* Boston: Harvard University Press

[2] Figueras Josep, Saltman Richard & Mossialos Elias (1997), Challenges in Evaluating Health Sector Reform: An Overview, LSE Health, Discussion Paper No. 8

[3] World Health Organization (1997), Health Sector Reform: Report & Documentation of the Technical Discussions, 54th Session of WHO Regional Committee for South East Asia, Thimpu, Bhutan, 8–12 Sept, 1997, WHO Regional Office for South East Asia: New Delhi.

[4] World Health Organization (2002), Health Situation in the South East Asian Region 1998-2000, Regional Office for South East Asia, New Delhi. pp. 189

[5] Thomason Jane A, Health Sector Reform in Developing Countries:A Reality Check: http://www.sph.uq.edu.au/acithn/conf97/papers97/thomason.htm Site last assessed on June 25, 2003.

Changes in financing methods

- User charges;
- Community financing schemes;
- Insurance;
- Stimulating private sector growth; and
- Increased resources to health sector.

Changes in health system organization and management

- Decentralization
- Contracting out of services; and
- Reviewing the public-private mix.

Public Sector Reform

- Downsizing the public sector;
- Productivity improvement;
- Introduction of competition;
- Improving geographic coverage;
- Increasing role of local government; and
- Targeting role of public sector through packages of essential services.

Whatever may be the approach to the reform process, the goals and principles underlying health sector reform, in a formal sense, remain the achievement of efficiency, improving quality, preserving or promoting equity, and generating new resources for health care, sustainability of the health sector and the organizations and institutions that comprise it.

Genesis of Health Sector Reforms

The genesis of Health Sector Reforms can be traced to the early 1980s. Prior to the 1980s, health care provision was mainly publicly funded and organized through public health care services with the aim of improving equity in access to care. However, the 1980s saw a smaller role emerge for the State and a shift to a neo-classical paradigm. In the face of world recession, the oil shock of the late 1970s, the socio-political changes that occurred globally especially after the collapse of the Soviet Union, a fiscal crunch was felt by both developed and developing countries. As a consequence of the economic crisis of the early 1980s, there was a change in the economic policies of several developing countries. This situation was coupled with governments struggling to develop financing mechanisms in the context of severe income inequalities, low access and utilization of health services by the poor and overburdening of existing services due to increasing disease burden on account of communicable diseases especially AIDS. During this period, social sectors like education and health were increasingly squeezed financially and cutbacks were made in the state intervention in the health sector. The fiscal constraints coupled with pressure on health systems due to rising health needs led to many countries availing of loans from the 'Bretton Woods' institutions namely the World Bank and the International Monetary Fund, under the Structural Adjustment Programme.

Thus, during the period of 1980s to mid 1990s, health sector reforms were an attempt to respond to the serious

challenges posed by the collapsing health service delivery systems in many poor countries and reforms were particularly concerned with re-defining the relationships between the state, service providers, users and other health related organizations *(Standing, H,2002).*[6] One of the foremost documents highlighting the change in role for the government and the enforcement of a new paradigm was 'Financing Health Services in Developing Countries', (World Bank, 1987)[7] which led to the Bank placing health financing at the centre of its policy dialogue with borrowers. This paper proposed four reforms: implementation of user charges at government health facilities; introduction of insurance or other risk coverage; usage of nongovernmental resources in a more effective manner, and introduction of decentralized planning, budgeting, and purchasing for government health services.

In terms of the overall macro environment, by mid-1990s, shifts began to occur in the pattern of international aid, bilateral aid budgets continued to decline as a total proportion of international transfers to the poor countries. There was however, an increase in the proportion of loans from multilateral agencies, particularly for social expenditures such as health. This was in part due to the concern being expressed over the impact of Structural Adjustment Programmes on the social sectors. This period saw a move away from donor specific project funding to sector investment programmes and approaches (SWAPs). There was a more broad based thinking not only on the technical aspects of reforms but also on needs and concerns of users and the importance of involving a wide range of stakeholders. Trends towards decentralization, continued growth and use of private provision of health services persisted, leading to an emphasis on governance, accountability and regulatory issues *(Standing H, 2002).*

A path breaking document the *World Development Report (WDR), 1993* titled, 'Investing in Health', provided the blueprint for health sector reform for developing countries[8]. The WDR 1993[9] proposed a three pronged approach to government policies for improving health. These included: (a) Fostering an environment that enables households to improve health, (b) Improving government spending on health, (c) Promoting diversity and competition. The overall role envisaged for the government was that of promoting economic growth. The report also recommended improvement in government spending on health in a manner that benefits the poor. The methods suggested included reduction of government expenditures on tertiary facilities, specialist training; implementation of user fees to affluent patients using the government hospitals and services, financing and implementing a package of public health interventions and essential clinical services and improving the management of government health services through measures such as decentralization of administrative and budgetary authority and contracting out of services. It suggested adoption of policies which encouraged social or private insurance for clinical services outside the purview of essential services being provided by the government, encouragement of suppliers, both in private and public sector to compete both to deliver clinical

[6] Standing Hilary (2002), An Overview of Changing Agendas in Health Sector Reforms, Reproductive Health Matters, Vol. 10, No 20, pp. 19 – 28, Elsevier Science.

[7] World Bank (1987),Financing Health Services in Developing Countries: An Agenda for Reform. A World Bank Policy Study, Washington

[8] This paradigm included changes in the conceptualization, planning, and delivery of health services, apart from new ways of health financing.

[9] World Bank (1993), World Development Report - Investing in Health.

services and to provide inputs to publicly and privately financed health services. Generation and dissemination of information of provider performance was also seen as a crucial role which required to be performed by the government.

With the publication of this document, the mid-1990s saw an increasing emphasis on assessment of priority health, with the global burden of disease analysis and associated priority setting methodologies becoming the recommended basis for planning and allocating health expenditure. This led to the development of basic packages and interventions based on assessments of greatest health needs and on maximum gain per unit of expenditure. Acknowledging the fact that the private sector was emerging as one of the main players in the health sector, attention was accorded to ways of regulating and harnessing the private sector in health delivery, thereby leading to experiments in contracting out of services amongst others.

The late 1990s to 2000s has seen the re-emergence of poverty as a global concern in the macro economic fora. Health has again come to occupy an important place in the international aid agenda, in view of the close linkages between poverty and health. This period has seen the emergence of initiatives like the Commission on Macro Economics and Health, development of poverty reduction strategy papers (PRSPs) and the Millennium Development Goals (MDGs) as well as the emergence of new international financing mechanisms like the Global Fund to fight AIDS, Tuberculosis and Malaria, the Gates Foundation, amongst others. While financial and institutional reforms, as also regulations have continued to be important issues in the health reform process, increasing stress is being laid on governance and accountability issues. The underlying conditions necessary for economic and social development and the role of governments as regulator in the context of multiple players and interests is assuming increasing significance. This has meant a greater role for the civil society in developing mechanisms to hold the governments as well as service providers accountable. *(Standing H, 2002)*

Hence, it can be seen that there have been different generation of reforms, which differ subtly in emphasis and premises. For example, while the first generation of adjustment policies ascribed importance to the stabilization measures, the second-generation of reforms focused on structural and institutional issues. The current third-generation adjustment policies are placing a special emphasis on poverty reduction, transparency, accountability and democracy.

Health Sector Reforms in India

While economic liberalization in India can be traced to late 1970s, it was only in 1991 that reforms began in earnest. Dwindling foreign reserves, negative growth of exports, soaring inflation, culmination of fiscal profligacy during the 1980s, high cost import substitution policies coupled with a balance of payments crisis set off by the Gulf War opened the way for an International Monetary Fund (IMF) program that led to the acceptance of a major reform package. The situation was compounded by a quick succession of changing governments. This was coupled with a realization which had been gaining ground in policy making circles that a

major change of economic system was needed, which led to the initiation of a wide ranging programme of reform. The program which consisted of stabilization-cum structural adjustment measures was put in place with a view to attain macroeconomic stability and higher rates of economic growth.[10] This occurred in a larger deteriorating public health scenario, wherein on hand, communicable diseases persisted and some of them like malaria had developed insecticide resistant vectors while others like Tuberculosis were increasingly becoming drug resistant and HIV / AIDS was assuming extremely virulent proportions. On the other hand, non-communicable diseases were arising as a result of life style changes and increase in life expectancy.

Hence, in the Indian context, reforms per se were a response to the view that in spite of some gains, the earlier regulatory model of development, had not delivered the expected results. These reforms sought to achieve rapid economic development, to improve the living standards of the people and ensure their development, to eliminate poverty, to protect human rights and to ensure people's participation, especially that of excluded groups. They aimed at closing the gap between India's potential and actual performance. The essence of the reforms was to increase the productivity of all sections of the society by making competition free and access to markets easier[11] *(Economic Advisory Council, GOI).* Though India's reforms have been piecemeal and incremental, the reforms of the last decade have gone a long way towards freeing up the domestic economy from state control. The state monopoly has been abolished in virtually all sectors, which have been opened to the private sector. The impact of policy trends towards greater deregulation, liberalization and integration with the global economy has been felt in the health sector too.

Content of Health Sector Reforms in India

In India, there has been a gradual shift in the organization, structure and delivery of health care services. Some of the important policy shifts as enumerated in the Eighth, Ninth and Tenth Five Year plans are described below.

The Eighth Five Year Plan[12] (1992-1997) was the first plan document to state the need for re-structuring of economic management systems, following the macro developments of the 1990s. During this period in the health sector, the concept of free medical care was revoked and people were required to pay, even if partially, for the health services. This led to the levying of user charges from people above the poverty line for the diagnostic and curative services offered in health institutions while free access or highly subsidized access was ensured to the needy. The plan also encouraged other initiatives with the private sector.

The Ninth Five Year Plan[13] (1997-2002) emphasized the need to review the response of the public, voluntary and private sector health care providers as well as the population themselves to the changing health scenario, to reorganize health services to bring about greater efficiency and effectiveness and to introduce health system reforms to enable the population to obtain optimum care at affordable cost The Ninth Plan sought to increase the involvement of voluntary, private

[10] Bajpai Nirupam (2002), A Decade of Economic Reforms in India: the Unfinished Agenda, CID Working Paper No. 89: Center for International Development, Harvard University.

[11] Government of India (2001), Economic Reforms: A Medium Term Perspective; Recommendations of Prime Minister's Economic Advisory Council.

[12] Government of India, Eighth Five Year Plan, (1992-1997) Planning Commission, New Delhi.

[13] Government of India, Ninth Five Year Plan, (1997- 2002) Planning Commission, New Delhi

organisations and self-help groups in the provision of health care and ensure inter-sectoral coordination in implementation of health programmes and health-related activities as well as enable the Panchayati Raj Institutions (PRI) in planning and monitoring of health programmes at the local level so as to bring about greater responsiveness to health needs of the people and greater accountability; to promote inter-sectoral coordination and utilise local and community resources for health care. The suggested health system reforms wherein the public sector would play a lead role, were structural, functional and governance related.

The Tenth Five Year Plan[14] (2002-2007) touches upon reforms at primary, secondary and tertiary level. The suggested reforms are similar to those mentioned in the Ninth Five Year Plan. It is recognized that health sector reforms needs to address the issues of equity and need to devise a targeting mechanism by which people below the poverty line have ready access to subsidized health services to meet their essential health care needs and that simultaneously efforts are made to build up an appropriate mechanism of payment for health care by other segments of population. The plan also emphasized the need to explore mechanisms for providing near-universal coverage of the population for meeting the cost of hospitalization and continuous care for chronic disease. It suggests that health finance options may include health insurance for individuals, institutions, industries and social insurance for below poverty line (BPL) families.

The reforms envisaged in the Plan documents[15-16] are detailed below.

Structural & Functional Reforms

- Reorganization and restructuring of existing health care infrastructure including the infrastructure for delivering ISM&H services at primary, secondary and tertiary care levels;
- Human resource development;
- Skill up gradation of health care providers through CME and redeployment of the existing health manpower;
- Horizontal integration of current vertical programmes including supplies, monitoring, IEC, training and administrative arrangements;
- Formation of a single health and family welfare society at state and district levels,
- Building up an effective system of disease surveillance and response at district, state and national level

Financial Reforms / Resource related reforms:

- Provision of essential primary health care, emergency life saving services, services under the National disease control programmes & National Family Welfare programme totally free of cost to individuals based on their needs & not on their ability to pay;
- Evolving, testing & implementing suitable strategies for levying user charges from people above poverty line while providing free service to people below poverty line & utilization of collected funds locally to improve quality of care;

[14] Government of India, Tenth Five Year Plan (2002-2007) Planning Commission, New Delhi

[15] Planning Commission, Annual Report (2001-02), Govt. of India, New Delhi

[16] Planning Commission, Annual Report (2002-03), Govt. of India, New Delhi

- Building up efficient and effective logistic system for supply of drugs, vaccines and consumables based on the need and utilization.

- Evolving & implementing a mechanism to ensure sustainability of ongoing government funded Health & Family Welfare programmes, especially those with substantial external assistance.

Governance related

- Introduction of comprehensive regulations prescribing minimum requirements of qualified staff, conditions for carrying out specialized interventions & a set of established procedures for quality assurance;

- Evolving standard protocols for care for various illnesses at primary, secondary & tertiary care settings;

- Quality Assurance & redressal mechanism such as Consumer Protection Act & Citizens' Charter for hospitals;

- Involvement of the Panchayati Raj Institutions (PRIs) in planning, monitoring of ongoing programmes and making timely corrections for optimal utilization of services.

- Appropriate delegation of powers to PRIs

Another area where reforms have been underway pertains to *public – private participation in health care.* A wide variety of public-private collaborative efforts have been reported by different States.

- Involving private sector practitioners in the National Programmes (E.g. Blindness control programme, utilization of NGOs and not-for-profit institutions in leprosy and HIV/AIDS programme);

- In states where private practices for government doctor is allowed, 80% of the doctors in government services, practice either in their own private clinic or work in a private clinic as a consultant.

- In some states after due orientation training, private practitioners trained in modern medicine or ISM&H, are given the responsibility of manning a primary health care centre where government doctor is not available;

- Private practitioners, especially specialists, are hired on a contract basis to provide specialist care in PHC / CHC under the RCH Programme

- Private sector individuals/institutions such as Tata Iron & Steel Company (TISCO) provide health care to the population living in a defined area.

- Private sector institutions / companies contribute to meet health care needs of a population living in the vicinity of their factory.

- Private super speciality, tertiary/ secondary care hospitals given permission to import equipment without duty, with the proviso that they provide free in-patient/out-patient services to BPL patients.

- Private super-speciality, tertiary / secondary care hospitals given land, water & electricity at a concessional rate with the proviso that free in-patient/out-patient services are provided to BPL patients.

- Private practitioners provide information for disease surveillance.
- Part time hiring of general practitioners & specialists to visit & provide health care in PHCs/CHCs in under-served areas;
- Engaging private agencies for support services like kitchen, laundry, cleaning and security
- Inviting the private sector to set-up medical colleges.

The impact of all these on improving access to health care at affordable cost and improving control of communicable diseases have not yet been evaluated. However, available information suggests that these schemes had succeeded in places where there was a well defined committed group to ensure that the MOUs were implemented fully. The Tenth Plan aims to build on the recommendations of the Ninth Plan and take up on a priority basis, documentation of such collaborations between private sector and public sector institutions and the role each of them play in outpatient/ inpatient health care in different districts/states. Attempts would also be made to improve area-specific public-private collaborations, taking into account the health care needs of the population, the presence of each of these sectors, their strengths and weaknesses. Furthermore, appropriate policy initiatives would be taken to define the role of government, private and voluntary sectors in meeting the growing health care needs of the population at an affordable cost.

Reforms initiatives underway at the Centre

The Central Government seeks to incorporate elements of reform, particularly in areas of decentralization, involvement of the private sector (including NGOs) and civil society, contractual appointment of staff though various programmes implemented under the aegis of the Department of Health, Family Welfare & AYUSH.

(I) Department of Health (DoH)

In keeping with the various reform initiatives highlighted in the policy and the plan documents, the Department of Health has attempted to incorporate reform elements within the various Centrally Sponsored Programmes. The Centrally Sponsored Programmes currently underway are:

Control of Communicable Diseases

- National Vector Borne Disease Control Programme (Malaria[17], Kala-Azar, Japanese Encephalitis, Filaria & Dengue)
- National Leprosy Eradication Programme
- Revised National Tuberculosis Control Programme[18]
- National AIDS Control Programme[19] (Including National STD Control Programme)
- National Surveillance Programme for Communicable Diseases & Integrated Disease Surveillance Programme
- National Polio Surveillance Project (NPSP)

[17] National Programme for Control of Malaria http://www.whoindia.org/CDS/CD/RBM/roll_back_malaria.htm

[18] Tuberculosis Control India, Directorate of Health Services, Ministry of Health & Family Welfare – http://www.tbcindia.org/

[19] National AIDS Control Programme http://www.naco.nic.in/nacp/welcome.html

Control of Non-Communicable Diseases

- National Blindness Control Programme[20]
- National Mental Health Programme
- National Cancer Control Programme
- National Iodine Deficiency Disorders Control Programme

This section briefly outlines the key reform initiatives in the area of decentralization through the formation of district level societies and attempts at bringing about collaboration with the private (including NGOs) sector with reference to the National Vector Borne Disease Control Programme, Revised National Tuberculosis Control Programme; National AIDS Control Programme and National Blindness Control Programme.

(A) Formation of District Level Societies

The National Malaria Control Programme(NMCP)[i] was launched in 1953 with the objective of bringing down malaria transmission to a level at which it would cease to be a public health problem[21]. Subsequently with World Bank assistance the Enhanced Malaria Control Programme (EMCP) was taken up in eight states with effect from 1997. This World Bank financed project, aims to strengthen the quality and effectiveness of malaria control strategies and activities in areas and population with the greatest need by capacity building; improved planning and management, especially at district level; strengthening community linkages in planning, implementation and evaluation of malaria control activities; process development to identify appropriate strategies for insecticide-treated mosquito nets and collaborative multi-disciplinary operational research to improve the implementation of malaria control strategies and activities and strengthening of surveillance systems and epidemic control capacity.

The formation of District Malaria Control Societies (DMCS) has been envisaged under the EMCP with a view to provide the districts greater freedom to execute the EMCP as well as have greater accountability. Under the NAMP[21], District Societies are established in each district. In terms of composition of members, the District Malaria Control Society (DMCS) has 12 members[ii]. Authority rests with the Governing Council, the Chairman, the Member Secretary and any other constituted authority. The functions of the Governing Council include, inter-alia, approval of annual budget, consideration and approval of annual accounts, alteration and revision of rules and regulations, inspection and supervision in terms of implementation of schemes under the NAMP, appointment of Malaria link workers and monitoring of their work amongst others.

The main functions of the DMCS include, periodic assessment of the malaria problem in the state and preparation of operational plan for the district, implementation of malaria control through logistics management, involving local NGOs and private

[20] National Programme for Control of Blindness & Eye Awareness http://mohfw.nic.in/kk/95/i9/webnpcb/default.htm
As part of its revised strategies, the programme seeks to expand the project activities at the district level, strengthen participation of voluntary organizations in the programme and to earmark geographic areas to NGOs and government hospital to avoid duplication of effort and improve the performance of the various government units. Schemes for NGOs- http://mohfw.nic.in/kk/95/i9/webnpcb/index.html#Schemes

[21] Government of India (2002), Guidelines for the District Malaria Control Society.

practitioners in malaria control activities especially distribution of medicated mosquito nets, co-ordination of activities between various health departments and other sectors, health education activities, monitoring and control of funds and mobilization of local resources. The guidelines also specify the procedure of fund flow from the NAMP to the district societies, the terms of reference for district level accounts, preparation of annual accounts, procurement policy and use of vehicles amongst others.

A similar structure of District Societies have been set up for the other National programmes, which include, Leprosy, Tuberculosis, AIDS, and Blindness.

The **Revised National Tuberculosis Control Programme** (RNTCP) is implemented through TB societies at the State and district levels with the responsibility for effective implementation lying with the State TB Officer and District TB Officer respectively. The State level society is headed by the State Health Secretary while District TB Societies are headed by the District Collectors.

As part of the **National AIDS Control Programme,** State AIDS Cells were created in all the 32 States and UTs of the country for the effective implementation and management of National AIDS Control Programme. However over a period of time, it was realized that due to many cumbersome administrative and financial procedures, there was delay in release of financial outlay sanction by Government of India due to which the implementation of the Programme at different levels suffered. In order to remove the bottlenecks faced by the programme implementation at State level, Ministry of Health and Family Welfare advised the State Governments/Union Territories to constitute a registered society under the chairmanship of the Secretary Health. The society, called State AIDS Control Society is broad based, with its members representing various ministries like social welfare, Education, Industry, Transport, Finance as well as non government organizations (NGOs).

With a view to decentralize the implementation of the **National Blindness Control Programme**[iii], a scheme for setting up a District Blindness Control Society (DBCS) was launched in the year 1994-1995 with the objective of decentralizing the implementation of the programme. The primary purpose of the District Blindness Control Society is to plan, implement and monitor all the blindness control activities in the district under the overall guidance of the State/Central organization for the National Programme for Control of Blindness. The Society is a forum where government, non-government and private sectors are represented and they plan, implement and monitor blindness control activities in the district as per the guidelines by Government of India. The DBCS are also involved in social mobilization and public awareness, procurement and orientation of various health functionaries. The societies are given grant-in-aid by Government of India to carry out assigned functions including assistance to NGOs for performing free cataract surgeries.

In terms of composition of the DBCS, it may have a maximum of 15 members, consisting of not more than 8 ex officio and 7 other members[iv] To improve the functioning of DBCS and ensure a smoother flow of

funds, the DBCS is required to prepare Annual District Action Plans to ensure a wider coverage of the services. Besides facilitating the preparation of the physical and financial plan, guidelines and norms for utilizations of funds by the DBCS have also been finalized by the GOI. For release of funds, by GOI, the DBCS needs to submit stipulated documents by 30th June of the current financial year. The funds provided to the District Blindness Control Societies can be utilized for the stipulated purposes and in accordance with the indicated financial limits. These include, inter-alia, remuneration to the Member Secretary; procurement of consumables including drugs, medicines and instruments; maintenance, hiring and maintenance of vehicles, IEC, provision of grant-in-aid to voluntary organizations, payment to NGOs, training assistance and secretarial assistance amongst others.

(B) Participation from the private / NGO sector

A programme which actively encourages participation from the NGO sector is the National AIDS Control Programme[v] (NACP) - Phase II. Two of the reform related objectives of the project include, decentralization of service delivery to the States and Municipalities and a new facilitating role of National AIDS Control Organisation (NACO) and encouragement of management reforms, such as better-managed State level AIDS Control Societies and improved drug and equipment procurement practices. Furthermore, the programme lays emphasis on delivery of priority targeted interventions through non government organizations, community based organizations and the public sector; provision of preventive interventions for the general population; provision of low cost care for people living with HIV/AIDS, institutional strengthening and inter-sectoral collaboration, which promotes collaboration amongst the public, private and voluntary sectors. It is apparent that NGO collaboration is the cornerstone of the NACO programme strategy. NACO has developed detailed guidelines[vi] for selection, capacity building, funding and monitoring of NGOs[22]. Additionally, provisions are made for the appointment of an NGO Advisor[vii].

The overall implementation of the project is under the aegis of the National AIDS Control Policy, which was formulated and approved by the National AIDS Committee[viii]. In order to strengthen the programme management at the state level, the state Governments have established their own managerial organizations which include State AIDS Control Societies (formerly, State AIDS cells), Technical Advisory Committees and Empowered Committees as per the guidelines of the strategic plan. Furthermore, at the state level, an Empowered Committee has been constituted by the states either under the chairmanship of Chief Secretary or Additional Chief Secretary at par with the National AIDS Control Board at central level. Moreover, mechanisms have been laid down for effective monitoring and evaluation of the Phase-II of the National AIDS Control Project at National and State level.

As part of the development of the National Tuberculosis Control Programme (NTCP) / Revised National Tuberculosis Control Programme[ix] (RNTCP) the Central TB Division (CTD) has begun to encourage the development of public-private partnerships to assist in

[22] NGO guidelines - http://www.naco.nic.in/nacp/guide2.htm

the rapid expansion of the DOTS strategy. This has taken two forms, namely, involving the private practitioners and involvement of NGOs.

Non-inclusion of other providers of TB-care, notably private providers, has been identified as one of the main reasons for the failure of the earlier programme, especially since private providers are reported to be the first point of contact for more than two-thirds of TB symptomatics. This realization led to the development of guidelines for involvement of the private medical practitioners in the RNTCP by the Central TB Division (CTD), Ministry of Health and Family Welfare, in 2002. According to the CTD, there are more than 1500 Private Practitioners (PPs) involved in the RNTCP. The Mahavir Hospital project in Hyderabad City, Andhra Pradesh is one of the first documented PPM projects while a project in Delhi to study three different models of private sector involvement, has contributed to the development of the PPM guidelines for the RNTCP. The GoI has initiated a Public Private Mix (PPM) pilot project with technical assistance from WHO in 14 sites across the country, viz. Ahmedabad, Bangalore, Bhopal, Chandigarh, Chennai, Delhi, Jaipur, Kolkata, Lucknow, Patna, Pune, Bhubaneswar, Ranchi and Thiruvanthapuram. This project seeks to increase case detection by enhancing involvement of the private sector in RNTCP.

As per the guidelines[23] all PPs can support and encourage effective tuberculosis control by:

- Referral of patients suspected of having TB[x]
- Provision of Treatment Observation[xi]
- A Designated Paid Microscopy Centre Microscopy only[xii]
- Designated Paid Microscopy Centre - Microscopy and Treatment[xiii]
- Designated Microscopy Centre - Microscopy only[xiv]
- Designated Microscopy Centre - Microscopy and Treatment[xv]

Recognizing the vital role of Non-Governmental Organizations (NGOs) in health promotion, service delivery, planning, programming, implementation, training and evaluation, the Government of India has developed guidelines[24] for involving them in the RNTCP. The Indian Medical Association (IMA) and its state branches, the TB Association of India with its state affiliates and similar institutions as well as NGOs active/interested in the field of TB control are also proposed to be appropriately involved in the RNTCP. Planned activities also include ensuring the participation of NGOs as partners in the RNTCP by way of inviting representatives of NGOs to serve as members of the coordination committees at the different levels; providing interested NGOs with information and literature on the RNTCP on a regular basis; involving NGOs in the planning, implementation and evaluation of the TB control programme through the National Tuberculosis Coordination Committee, State Tuberculosis Coordination Committee and the District Tuberculosis Control Societies; inviting NGOs to visit pilot sites to get a better understanding of the RNTCP and share their knowledge of working with TB patients/ providers; inviting NGOs working in the district and

[23] Ministry of Health & Family Welfare (2002), Involvement of Private Practitioners in the Revised National Tuberculosis Programme, Central TB Division, Directorate General of Health Services.

[24] Ministry of Health & Family Welfare (2002), Involvement of Non-Governmental Organisations in the Revised National Tuberculosis Programme, Central TB Division, Directorate General of Health Services.

willing to be involved in the RNTCP to furnish details of their activities and areas of coverage; inviting NGOs to participate in RNTCP training. District level officials (District Tuberculosis Officer, Chief Medical Officer, etc.) and members of the District Tuberculosis Control Society (DTCS) are required to assist the NGO in ensuring smooth cooperation and coordination with the different government health care facilities.

The areas of collaboration with NGOs include:

- Health education and community outreach[xvi]
- Provision of directly observed treatment[xvii]
- In-hospital care for tuberculosis disease[xviii]
- Microscopy and treatment centre[xix]
- TB Unit Model[xx]

Presently, around 550 NGOs and 200 PPs are already involved in RNTCP. Attempts are also underway for involvement of other sectors through the formation of a National level and Zonal Task Force for involvement of Medical Colleges and subsequent involvement of medical colleges in RNTCP.

Working with voluntary / non-governmental organizations forms a crucial part of the National Blindness Control Programme too. The purpose of the various schemes is to reduce the prevalence of blindness, particularly cataract and corneal blindness through involvement of voluntary organizations by providing package of services. Financial assistance to voluntary organizations, is offered in the form of (a) Grant in aid for performance of free cataract operations on blind persons in NGO base hospitals from assigned geographical area through reach-in-approach (Rs.400 for Conventional/Rs.600 for IOL surgery with an increase of Rs. 50 respectively for tribal and remote areas); (b) Grant-in-aid to NGOs for assistance in clearing backlog of cataract blind persons through screening of at risk population, preparation of blind registers, motivation, transportation, free cataract surgery in assigned government base hospitals and follow up services (Rs.125 per case); (c) Grant-in-aid to NGOs for organizing eye camps including free cataract surgery in identified underserved areas; (d) Non-recurring grant-in-aid to NGOs for expansion or upgradation of eye care units in tribal, underserved or backward rural areas (Maximum Rs.17.75 lakhs); and (e) Grant-in-aid to NGOs for setting up/strengthening of eye banks (Non-recurring Rs.5 lakhs, and recurring upto Rs.500 per case)

To be eligible, a voluntary organization is required to be registered under the Indian Societies Registration Act, 1860 (Act XXI of 1860 or any such act resolved by the State) or be a Charitable Public Trust registered under any law for the time being in force; have experience in providing health services preferably eye care services over a minimum period of 3 years; have available well-trained staff, infrastructure and the required managerial expertise to organize and carry out various activities under the scheme; and agree to abide by the guidelines and the norms of the programme.

(II) Department of Family Welfare (DoFW)

The National Population Pclicy 2000 (NPP 2000[25]) seeks to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental protection. The envisaged strategies for meeting the policy objectives inter-alia include, formation of a forum of representatives from government, NGOs and private sector to identify hurdles in collaboration, NGOs to assist in advocacy, counseling and clinical services at village levels, rewarding Panchyats and Zila Parishads for exemplary performance, the Maternity Benefit Scheme and a Family Welfare-linked Health Insurance Plan. The announcement of the NPP 2000 was followed by the constitution of the National Commission on Population, as also a National Population Stabilisation Fund, which was envisaged to provide a window for canalizing monies from national voluntary sources and to specifically aid projects designed to contribute to population stabilization. Though the Fund was registered in June 2003, and provided a Rs. 100 crore kitty by the government, it is yet to be operationalized.

The Department of Family Welfare has also made efforts to enhance the quality and coverage of family welfare services through increased participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of practitioners of ISM&H. Under the RCH programme, several initiatives are underway to improve collaboration between the public and private sectors in providing family welfare services to the poor, especially in the under-served areas.

In the area of maternal health, contractual appointment of staff is being undertaken. With a view to ensuring better emergency obstetric care in category 'C' districts across 8 states (where the status of RCH is poor and infrastructure, roads and electricity is weak, the outreach of ANMs is difficult) in 30% of sub-centers, which qualify to be categorized as remote sub-centers, one additional ANM on contractual appointment, is provided under the RCH programme. The input is also available for appointment of 140 ANMs in Delhi for extending their services in slum areas. The scheme has been expanded to all North Eastern States with effect from 1999-2000. Similarly, Public Health Nurse / staff nurses are appointed on a contract basis at PHCs / CHCs having adequate infrastructure for conducting deliveries. Furthermore, in order to plug deficiencies in providing emergency obstetric care at FRU due to non-availability of anaesthetist for surgical interventions, states have been permitted to engage the anaesthetist from the private sector on a payment of Rs.1,000 per case and this facility is available at sub-district and CHC level but only for emergency obstetric care. With a view to supplement the regular arrangement, provision has been made for engaging doctors trained in MTP as Safe Motherhood Consultant who will visit the PHC (including CHCs in NE States) once a week or at least once in a fortnight on a fixed day for performing MTP and other Maternal Health care services. These doctors will be paid @Rs.500 per day visit. A scheme for reservation of sterilization beds in hospitals run by government, local bodies and voluntary organization was introduced in 1964 with view to provide immediate facilities for tubectomy operations in hospitals. At present too, beds are

[25] Government of India (2000), National Population Policy 2000, Department of Family Welfare, Ministry of Health and Family Welfare.

sanctioned to hospitals run by local bodies and voluntary organizations and grant-in-aid is provided as per approved pattern of assistance.

Involvement of NGOs in the Family Welfare Programme

In pursuance of efforts towards population stabilization and RCH, aimed at inculcation of a meaningful relationship with NGOs, the GOI has developed revised guidelines for NGO schemes[26]. These include the Mother NGO (MNGO) Scheme and the Service NGO (SNGO) scheme. The NGO programme is currently being implemented in 102 MNGOs in 439 districts, 800 FNGOs, 4 Regional Resource Centres (RRC) and 1 Apex Resource Cell (ARC).

Under the MNGO scheme, the DoFW has identified and sanctioned grants to selected MNGOs[xxi], who in turn issue grants to smaller NGOs called Field NGOs (FNGOs)[xxii] in the allocated districts. The FNGOs are involved in advocacy, service delivery and awareness generation. The functions of the MNGO include inter-alia, identification and selection of FNGOs; their capacity building; development of baseline data through CNAA; provision of technical support; liaison, networking and co-ordination with State and District health services, PRIs and other NGOs; monitoring the performance and progress of FNGOs and documentation of best practices. On the other hand, the FNGOs are required to conduct Community Needs Assessment, provision of RCH services, RCH orientation to PRI members, creation of conducive working environment for ANM, documentation, etc. Detailed procedural and process guidelines have been developed for MNGOs and FNGOs, which spells out the processes involved in selection, sanction and monitoring.

As per the Service NGO (SNGO) Scheme, SNGOs are expected to provide an integrated package of clinical and non-clinical services directly to the community. In order to provide these services effectively, the applicant NGO is required to have appropriate staff, infrastructure, etc. Indicative guidelines for RCH service delivery area along with details pertaining to the role and function of NGO Selection Committee, State RCH Society, State RCH Committee, State NGO Coordinator, District RCH Society, appraising and evaluation agencies have been detailed in the NGO guidebook. Procedural guidelines for submission of application and process guidelines for selection, funds release and monitoring have also been developed.

In terms of institutional framework, the GOI provides support through policy guidelines, approval and release of funds to the State RCH Society, Grants-in-Aid Committee (GIAC) which approves the MNGO project, recommended by the NGO Selection Committee. The NGO Selection Committee is constituted at the state level for the purpose of MNGO & SNGO selection and is chaired by the Joint Secretary, DoFW. Technical support for NGO capacity enhancement, documentation, induction, etc is given by the Regional Resource Centres (RRCs). The Apex Resource Cell (ARC), located within the NGO division co-ordinates the activities of all RCCs. The State RCH Society, which constitutes the State NGO Committee, ensures the placement of State NGO Co-ordinator. Selection of MNGOs, recommendation of projects, fund disbursement, capacity building, training,

[26] Government of India (2003), Guidelines for Department of Family Welfare Supported NGO Schemes, NGO Division, Department of Family Welfare, Ministry of Health and Family Welfare.

monitoring and evaluation is the responsibility of the State RCH Society. In the realm of public private partnerships[27], the DoFW is attempting to implement various models of PPP. This includes Haryana Urban RCH Model, which is to be implemented in 19 urban slums, and seeks to benefit 15 lakh beneficiaries. In this model, a private health practitioner (PHP) has been identified to provide comprehensive primary health care service to a group of 1000 – 1500 targeted beneficiaries. In turn, s/he would be made a payment of Rs. 100 p.a, per beneficiary by Government. The PHP would provide services relating to National Disease Control Programme, Contraception, immunization, ambulatory care. The programme seeks to be self-sustaining by the 5th year. Another attempt in this direction is the proposal submitted by PSS, Rajasthan to GOI for establishment of a comprehensive RCH clinic in 3 districts, wherein PSS would provide services like sterilization, MTP, spacing, ante/post natal care, immunization, RTI/STI. The cost to be borne by the government works to Rs. 18-20 lakh p.a per clinic. With a view to ensure project sustainability, the user fees is sought to be deposited in a bank account.

Under the aegis of the RCH programme, specific programme on ISM is also being implemented. This includes, training ISM practitioners, both in the government and NGO sector and orienting them in RCH concept and framework through a short-term training of 2-4 weeks to be conducted through ISM Medical Colleges.

(III) Department of AYUSH

The Department of AYUSH envisages accreditation of organizations with the MOHFW for research and development in order to be eligible for financial assistance under the scheme of Extra Mural Research on ISM&H. The organizations eligible for accreditation include R&D organizations recognized by the Ministry of Science and Technology, Government of India; one Government or semi-Government or autonomous R&D Institution under the GOI / State Government /Union Territory; and one private R&D institutions registered under any State/ Central Act as Research organization. The applicants seeking accreditation are required to submit 5 copies of application enclosing the necessary documents[xxiii]. The accredited organizations are required to abide by the stipulated terms and conditions.[xxiv]

Involvement of bi-lateral & multi-lateral agencies in health sector reforms

This section outlines the initiatives being undertaken by the World Bank, the European Commission supported Sector Investment Programme and the Department for International Development (DFID) in the area of health sector reforms in India.

The World Bank[28]

The World Banks' involvement in the health sector in India can be traced to the early 1970s, wherein the Bank funded five population projects (1972-88), which consisted of supporting the Family Welfare Programme. The re-organization of the Bank in 1987 marked a renewed commitment to human resource development and led to a rapid expansion of sector work. During this

[27] Singh S (2004), Public-Private Partnership in Healthcare with Special Emphasis on Family Welfare Programme, PowerPoint presentation at workshop 'Towards Public Private Partnerships in Health Care', EPOS Health Consultants(India) & Health Partnerships Forum-India, March 26,2004

period, various documents pertaining to the health, population and nutrition in India were developed. The focus during 1988-89 shifted towards Maternal & Child Health (MCH) with the initiation of the various Population Projects. Free-standing health projects, beyond the realm of Family Planning were only developed in 1990s. This included specific disease control projects to control AIDS, leprosy, cataract blindness, tuberculosis and malaria. These projects were designed to accelerate these National Programmes and improve their effectiveness. Furthermore, the Bank sought to bring about greater integration of the private sector in the government's health efforts through these programmes. It also introduced the concept of use of nonprofit registered societies (e.g. District Blindness Control Society, District Leprosy Society, etc) to advise on the design or implementation of these programmes. The Bank has also supported Health System Reform Projects[29] with a view to influence more fundamental determinants of how the public health system works, especially at the state level. The projects initially implemented in Andhra Pradesh, Karnataka, Punjab, West Bengal and later in Orissa and Maharashtra, included components to improve quality, access and effectiveness of health services at the first referral level, to strengthen management systems and to improve sector finances and resource allocation. While broad principles guide these various projects, the specific activities are regionally relevant.

EC Supported Health & Family Welfare Programme[30]

In October 1998, the European Commission (EC) supported Health and Family Welfare Programme was started and an EC Technical Assistance Team was put in place. The EC provides financial and technical support to the GOI over a period six years with a total EC contribution of Euro 240 million (approx. Rs. 1150 crore) through the Sector Investment Programme (SIP) - a form of Sector Wide Approach. Essentially, the SIP is designed to assist the Centre, states and districts to implement the policy reforms outlined in the GOI publication, 'The Paradigm Shift'[31] and related reforms that may emerge. The programme is an integral part of the Government of India's National Family Welfare Programme, and is implemented in coordination with the Department of Family Welfare (DoFW).

The one year, Programme Preparation Phase (PPP), inter-alia, consisted of GoI stakeholder dialogue, inter-donor dialogue, initiation of pilot studies and literature review. Several reports, situational analyses, working papers were developed and Policy Option Reviews were also conducted. The strategy for the SIP, includes slice analysis, preparation of District Action Plans (DAP), and operational policy reform dialogue. The programme has decentralized management structure set up in the form of Sector Reform Cells at the State level, integrated health and family welfare agencies at district level and autonomous management bodies at the facility level.

The programme has also developed a Policy Reform Options Database (PROD)[32] a database for health sector reform. PROD contains details of health sector reform options grouped according to strategic issues within health sector domains. The aim is to provide up-to-date and accurate information about options or

[28] The World Bank- www.worldbank.org/in

[29] The State Health System Projects have been discussed under the respective States

[30] GoI & European Commission, Health & Family Welfare Programme in India, SIP Document, November 1999.

interventions, using a standard format; and to organise such options systematically.

Focusing on institutional development and attitudinal change, and through a phased approach, the Programme is currently assisting over 60 districts in 24 states and several urban centers to enhance the quality of health care services for the disadvantaged population including tribals.

A Joint Steering Committee (JSC) approves major policies, overall direction of action and the annual plans. The Programme Management Bureau (PMB) is the Programme executive body which technically and financially approves state and district proposals, pilots and developmental activities, as well as national activities. The European Commission Health & Family Welfare Programme Office (ECHFWPO) or European Commission Technical Assistance (ECTA) team provides technical guidance and monitors the programme.

DFID[33]

The Department for International Development (DFID) works in close partnership with the Central Government and the state governments of its four focus states – Andhra Pradesh, Madhya Pradesh, Orissa, and West Bengal. It provides assistance in the field of Forestry, Slum Improvement, Energy Efficiency, Education, Renewable Natural Resources and Health & Family Welfare sectors. Its focus is primarily on meeting the internationally agreed Millennium Development Goals (MDGs) by 2015. Furthermore, the DFID seeks to assist the government in achieving the 10th Plan's poverty-reduction objectives, with a special focus on implementing more comprehensive approaches to poverty-reduction in partner states; more effective provision of services to the poor and creating an enabling environment for economic growth.

DFID is supporting the Government of India in its efforts to achieve goals of reduction in infant and child mortality as well as maternal mortality through support for a number of nationwide health initiatives. DFID is financing over 20% of the cost of the national polio vaccination campaign. It is also a principal supporter of the National AIDS Control Programme. DFID is seeking out new opportunities to focus more closely upon under five and maternal mortality. For instance, it is working with the Ministry of Health and Child Welfare, the UN and other development partners to develop the Reproductive and Child Health 2 (RCH2) Programme.

The DFID is involved in various initiatives in the four focus states. In Andhra Pradesh, DFID involvement in the health sector includes support to the government to develop a medium-term strategy to improve the access of all people, especially the poor, to good quality health services. In Madhya Pradesh, it extends support for continued pro-poor economic and social policy reform aimed at comprehensive poverty reduction. The DFID has also been involved in the development of an integrated policy response and health strategy. Its seeks to strengthen health planning and management at the district and lower levels in order to reinforce and support the processes of decentralization and a more participatory

[31] This booklet, issued in 1996, signaled GoI's intentions to reform the Family Welfare sector, along with the principles identified by the International Conference on Population & Development, Cairo, 1994. 'The Paradigm Shift' called for decentralization, community needs based planning, sustainability of infrastructure and workforce, more efficient financial management and improved quality of clinical services.

[32] PROD - www.prod-india.com

[33] DFID – www.dfidindia.org

approach to development. Currently , their involvement in the health sector in Orissa is in assisting in reducing infant and maternal mortality by supporting better managed and more appropriately targeted health care delivery systems. It supports the Government's strategy to address these and other health sector challenges over the next 10 years. The nature of its support in the health sector in West Bengal includes supporting the comprehensive health sector strategy (which is being developed) the subsequent operational plans for the State.

The next section briefly outlines the rationale for preparation of this document and the methodology adopted. It also provides a broad overview to reform initiatives underway at state level.

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[i] **National Malaria Control Programme**
Following successful field trials with DDT in different parts of the country the NMCP was extended to the National Malaria Eradication Programme (NMEP) in 1958. Resurgence of malaria in subsequent years led to the introduction of Modified Plan of Operation (MPO) in 1977. Following malaria epidemics in 1994, an Expert Committee formulated the Malaria Action Programme (MAP), which was taken up in 1995.

[ii] The District Collector / Chief Executive Officer serves as Chairperson while the District Malaria Officer is the Member Secretary. The other members include, Chief District Medical Officer, representatives from NGOs, District Indian Medical Association, Tribal Development or Social Welfare, District Irrigation department, Public Health Engineering department, District Education Officer an the District Media or IEC officer

[iii] **National Blindness Control Programme**: The National Programme for Control of Blindness was launched in the year 1976 as a 100% Centrally Sponsored Programme. In order to achieve its goal of reducing the prevalence of blindness from 1.4% to 0.3%, the programme seeks to develop an eye care infrastructure throughout the country; increase institutional capacity for eye care; expand coverage to underserved areas; enable decentralization up to the district level; develop human resources for eye care at all levels; improve the quality of eye care forbetter visual outcome and secure participation of non-government and private sector.

[iv]While the District Collector / Magistrate is the chairman of the DBCS, the Chief Medical Officer (CMO) / District Health Officer is the Vice Chairman. The CMO is responsible for close monitoring of the programme, under the guidance of and in accordance with the instructions issued by the Chairman. The Chief Ophthalmic Surgeon, District hospital/ Head (Ophthalmology) of Medical College (if any), serves as the Technical Officer. The other members include, the Medical Superintendent/Civil Surgeon of District h
ospital, District Education Officer, Project Director DRDA/ITDA, Ophthalmic Surgeon of Mobile Eye Unit, President, Indian Medical Association (Local), 3 Representatives of grass root level NGOs, District Mass media/IEC officer, and prominent practicing Ophthalmic surgeons. Furthermore, it is stipulated that there should be at least one woman and one SC/ST member in the DBCS.

[v] **National AIDS Control Programme**: The first phase of the National AIDS Control Project (NACP-I) was launched in 1992 under the tutelage of the National AIDS Control Organization. The first phase of the project was implemented between 1992 and 1999, with an extended period of 2 years. The ultimate objective of the project was to slow the spread of HIV to reduce future morbidity, mortality, and the impact of AIDS by initiating a major effort in the prevention of HIV transmission. A multi-sectoral approach was adopted in planning, implementing and monitoring of all the key project activities. The increasing incidence of HIV/AIDS epidemic necessitated the extension of NACP-I with larger objectives. As a result, the Phase II of the National AIDS Control Project (NACP-II) became effective from November 1999. NACP II has two key objectives: to reduce the spread of HIV infection in India; and to strengthen India's response to HIV/AIDS on a long- term basis.

[vi] **Selection of NGOs under the AIDS programme:** There exists an elaborate process for selection of NGO partners. First, an advertisement is issued in the newspapers, inviting proposals from NGOs. The NGOs who have applied, are assessed based on existing guidelines. The NGO is required to be registered as a legal organization, either under the Societies Registration Act, 1860 or the Charitable and Religion Act 1920; or Indian Trust Act, 1982; or with co-operative professional bodies such as IIPA, IMA at least for a period of three years. In terms of infrastructure, the NGO is required to the basic infrastructure in place; a stable organizational structure, established track record in the developmental field, especially with communities, so that it may effectively integrate HIV/AIDS with its ongoing programme, clean audit reports and a good working relationship with other NGOs. The project proposal submitted by the NGO is required to be accompanied by a copy of the registration certificate; annual report of the past three years; Non- Governmental Organization's Self Assessment Report; Audited financial report of the past three years; organogram of the NGO and a certificate from the NGO stating that it is not receiving funds for the activity mentioned in the proposal from any other national or international donor agencies or State Government. The NGOs are selected at State levels through the Technical Advisory Committees set up by the State AIDS Control Societies (SACS). These committees scrutinize candidate applications and project designs, and also subsequently monitor and evaluate the programme within the framework of the guidelines drawn up by

NACO in respect of each intervention. The SACS provide financial assistance and sustained technical support in project implementation. All the proposals received from the NGOs are placed before a Technical Advisory Committee (TAC), consisting of technical advisors of the SACS and the NGO members of the Executive Committee of the SACS. Wherever possible, a member of NACO is also part of the selection committee. The TAC scrutinizes the proposals with reference to the priority-targeted intervention identified for the State/MC in its final Project Implementation Plan. Those NGOs whose proposals are recommended by the TAC for modification are informed of the decision and invited to participate in a short Orientation Training Program (OTP). The approved proposals are taken up for field inspection by a Joint Appraisal Team (JAT) consisting of an officer of SACS who has been designated as Zonal Officer for specific districts and one of the NGO members of the TAC. The field inspection report of the Joint Appraisal Team, along with the TACs recommendations are placed before Executive Committee of SACS, chaired by the State Health Secretary, for consideration and decision. The NGOs whose proposals are approved thereafter enter into an agreement with the SACS. The funds for the proposed activity are released as per the stipulated guidelines.

[vii] **NGO Advisor:** The appointment of an NGO advisor is through an open and transparent process. First, an advertisement is issued in the local newspapers for the post of NGO Advisor.Thereafter, a selection committee is formed. It is mandatory that a representative from NACO is a member of the selection committee. In terms of qualifications, it is stipulated that the NGO advisor has a Masters degree in Social Work or any other social science discipline such as Sociology, Anthropology etc; that his / her age is between 25-50 years and that he/she has at least two years experience in the NGO sector preferably in the health sector. The position is temporary and on a contract basis, for aninitial period of one year.

[viii] This committee was formed in 1986, with a view to bring together various ministries, non-Government organizations and private institutions for effective co-ordination in implementing the programme. It acts as the highest-level deliberation body to oversee the performance of the programme and to provide overall policy directions, and to forge multi-sectoral collaborations.

[ix] The Integrated National Tuberculosis Control Programme (NTCP) was established in 1962 as a decentralized programme. Following an evaluation in 1992 and based on the recommendations of the Expert Committee, a significant overhaul of the NTCP and the adoption of a new approach to TB control were undertaken. This new approach is called the Revised National Tuberculosis Control Programme (RNTCP). RNTCP is an application of the WHO-recommended Directly Observed Treatment, Short Course (DOTS) strategy to control TB with the objective of curing at least 85% of new sputum positive TB patients and detecting at least 70% of such patients. RNTCP seeks to cover the entire country by 2005 in order to meet the global targets of TB control.By end of 2001, a population of 450 million in 221 districts in 21 States /Union Territories had been covered under RNTCP.

[x] **Referral of patients suspected of having TB** wherein the PP refers patients or sputum samples of patients with cough for three weeks or more to designated microscopy centre, providing treatment. The physician can charge the patient for consultation but not for sputum collection or their transportation or examination. Patients with non-pulmonary TB may also be referred for the initiation of treatment to the government health services along with proper results of the investigation. In this scenario, the District TB Control Society/ District TB Centre would inform private practitioners of location, timings service charges of private microscopy centers, if any, of designated microscopy centres & ensure that they provide quality services according to RNTCP guidelines. In terms of grant-in-aid, Rs.10 is paid per sputum sample to PP or staff of PP for despatch of sputum samples to the designated microscopy centres.

[xi] **Provision of Treatment Observation**wherein the private practitioners or their staff provide DOTS to patients as per RNTCP guidelines. The Private Practitioner can provide treatment observation either at one of their own facilities, or at any other mutually convenient place to the patients. The patients may either have been referred by PPs or may have been diagnosed elsewhere and referred to the PP for direct observation at the request of the patient. The private practitioners could be individual physicians or from other private sector like an industrial house, public sector undertaking, etc. The PP is required to provide regular information regarding the progress of the patient, default retrieval action taken, to the supervisory staff of the DTC. The DTCS will orient and train persons chosen by the PP for providing directly observed treatment. TB programme staff (including Senior Treatment Supervisors, TB Health Visitors, etc.) will maintain regular contact with those who give observed treatment by visiting them periodically and will assist with initial visit, address verification and defaulter retrieval, whenever required. DTCS will offer periodic Continuing Medical Education (CME) sessions for PPs who are involved in the programme. Rs. 175 is provided to the treatment observer for each patient cured/completed treatment, to be disbursed after cure/completion of treatment.

[xii] **A Designated Paid Microscopy Centre - Microscopy only** wherein a private health facility having its own laboratory, serves as an approved microscopy centre under RNTCP. The health facility is required to strictly adhere to RNTCP policies on sputum microscopy as outlined in the Manual for Laboratory Technicians and the Laboratory Technicians Module, including proper maintenance of a TB Laboratory Register. The District TB Control Society will provide training to the Laboratory Technician and other staff of the facility and thereafter provide technical monitoring of the quality of microscopy by the STLS and other TB control staff on a monthly basis or more frequently if required.

[xiii] **Designated Paid Microscopy Centre - Microscopy and Treatment** wherein a private health facility having its own laboratory, serves as an approved microscopy centre under RNTCP. In addition

to laboratory services for sputum microscopy, the microscopy centre serves as a treatment centre, providing categorization and treatment of patients. Microscopy and treatment policy is as per RNTCP, including diagnosis, categorization, and treatment of patients, record keeping and supervision by the staff of the DTCS. The microscopy centre may charge for its services but not for anti-TB drugs. Staff of the health facility like the medical officer, laboratory technician and the DOT provider must have successfully completed relevant training in RNTCP. The District TB Control Society will provide training to the MO, Laboratory Technician, and DOT provider of the facility or its unit. Thereafter it will provide technical monitoring of the quality of microscopy and quality of care on a monthly basis or more frequently if required. It is stipulated that the health facility has a medical officer possessing a minimum MBBS qualification who will be responsible for diagnosis, categorization and treatment of patients as per RNTCP guidelines.

[xiii] **Designated Microscopy Centre - Microscopy only** wherein a private health facility having its own laboratory serves as an approved microscopy centre and is designated as such by the RNTCP. Patients are not charged for AFB microscopy, and the materials for microscopy are provided to the microscopy centre. The District TB Control Society will provide training and technical guidance and perform laboratory quality control. Grant-in-Aid of Rs. 15 per slide, but subject to a cap and revocation if fewer than 4% of suspects examined are found to be AFB positive. Specifically, if less than 4% of TB suspects are found to be positive, then only 25 times the number of positive slides would be reimbursed, and the laboratory would be intensively supervised concerning selection of patients and performance of microscopy.

[xv] **Designated Microscopy Centre - Microscopy and Treatment** wherein a private health facility having its own laboratory, serves as an approved microscopy centre and is designated as such by the RNTCP. In addition to laboratory services for sputum microscopy, the microscopy centre serves as a treatment centre, providing categorization and treatment of patients. Patients are not charged for services, and the materials for microscopy and treatment are provided at the microscopy centre. Microscopy and treatment policy is as per RNTCP, including diagnosis, categorization and treatment of patients, record keeping and supervision by the staff of the DTCS. Diagnosis and treatment are provided free of charge to patients. Staff of the health facility like the medical officer, laboratory technician and the DOT provider must have successfully completed relevant training in RNTCP.

[xvi] **Health Education and Community Outreach** wherein the staff and volunteers of the NGO provide advocacy, information, education, and communication activities relating to tuberculosis and its treatment. In order to perform these functions, the NGO will sensitize and train volunteers, disseminate information, provide counselling to patients and families, sensitize, orient and advocate with key groups, and, if agreed, retrieve defaulters in their area. The grant-in-aid is payment for training will be as per government rates. A sum of Rs 5000 will be paid as annual incidental charges for postage, use of telephone, fax, transportation, etc for coverage of 10 lakh population.

[xvii] **Provision of Directly Observed Therapy** wherein the staff or volunteers of the NGO provide directly observed treatment (DOT) to patients on RNTCP treatment. The NGO would identify, train, and supervise volunteers who will be providing DOT. In terms of aid, a sum of Rs 175 will be paid to an individual volunteer for each patient cured. This is to be disbursed only after cure of the patient is established except as outlined in the Guidelines for the District TB Control Society. Alternatively, the District TB Control Society may pay an agreed-upon amount to the NGO, based on an estimate of Rs 175/patient and expected caseload, subject to actual disbursement of honorarium. Annual incidental charges of Rs 10,000 will be paid for postage, use of telephone, fax, transportation, etc. for every one lakh population and will be adjusted proportionately on the basis of population.

[xviii] **In-Hospital Care for Tuberculosis Disease** wherein the NGO provides in-hospital care for tuberculosis patients who require such care. As part of aid, annual incidental charges of Rs 20,000 will be paid for postage, use of telephone, fax, transportation, etc.

[xix] **Microscopy and Treatment Centre** wherein the NGO serves as a microscopy and treatment centre and is designated as such by the RNTCP. The NGO is responsible for ensuring the treatment or referral of all patients found to have a positive AFB smear, and for ensuring follow-up treatment and sputum examinations for all patients placed on treatment. The NGO must ensure referral for treatment of patients found to be smear-positive but who live outside the NGOs catchment area. Grant-in-aid includes annual incidental charges of Rs 50,000 will be paid for postage, use of telephone, fax, transportation, etc.

[xx] **Tuberculosis Unit Model** wherein the NGO provides all RNTCP services earmarked for a Tuberculosis Unit (TU; approximately 5 lakh population). Strict compliance with the Technical and the Operational Guidelines of the RNTCP is mandatory. In general, this model can only be considered in areas where the governmental infrastructure is not sufficient to ensure effective RNTCP implementation, and/or where an effective NGO is currently working in the field of health in this area.

[xxi] **NGOs applying for MNGO status** are required to fulfill laid criteria in terms of registration, experience, assets and jurisdiction. Furthermore, stepwise guidelines have been laid down for selection of MNGOs, the duration of grants, fund flow, monitoring, evaluation and reporting mechanisms.

[xxii] **NGOs applying for FNGO status** are required to fulfill laid criteria in terms of registration, experience, assets and jurisdiction. Furthermore, stepwise guidelines have been laid down for selection of MNGOs, the duration of grants, fund flow, monitoring and performance indicators.

[xxiii] A copy of the Memorandum of Association, Rules and Regulations of the organization under which it has been established ; A copy of registration certificate under the relevant Act; the area of research in

which the organization is engaged (in key words); Annual Report along with audited statement of accounts for the last year.

[xxiv] **Terms & condition** - Separate accounts for R&D activities and the same to be reflected in the Annual Report and Audited Statement of Accounts of the organization ; submission of brief summary of the achievements of the organization to the MOHFW every year; Conformation to other conditions for accreditation as stipulated in the guidelines or as may be specifically provided in the accreditation letter; Accreditation to be valid for a period of 3 years only; Submission of application in the prescribed proforma; Request for renewal of accreditation to be made on prescribed proforma three months before the expiry of the valid accreditation; The Ministry to reserve the right to accord accreditation or to revoke such accreditation without assigning any reason; Soon after receipt of accreditation letter, the organization to acknowledge by stating that they abide by the above terms and conditions.

Genesis of the Present Document and Methodology

GENESIS OF THE PRESENT DOCUMENT AND METHODOLOGY

The health sector in India is at crossroads today. On the one hand, India has built up a vast health infrastructure and manpower at primary, secondary and tertiary care in government, voluntary and private sectors. The population has become aware of the benefits of health related technologies for prevention, early diagnosis and effective treatment for a wide variety of diseases and accessed available services. Technological advances and improvement in access to health care technologies, has resulted in substantial improvement in health indices of the population and a steep decline in mortality. Yet at the same time, we continue to grapple with newer challenges with the country now being in the midst of a dual disease burden of communicable and non-communicable diseases. It is acknowledged that the existing public health infrastructure is far from satisfactory and that the public health system suffers from paucity of funds, lack of adequate manpower, non-availability of consumables, obsolete equipment and dilapidated infrastructure. In spite of this, the Government has taken several steps for improving the public health care institutions and strengthening the primary health care infrastructure. However, the situation is compounded by severe resource constraints – financial, technical and human power related, which has resulted in policy makers as well as programme managers at differing levels being faced with difficult choices. In such a situation, attempts are being made through various reform initiatives to ensure that the health needs of the people are met. In face of problems like suboptimal functional status and difficulties in providing adequate investments for improving health care facilities in the public sector, almost all the state governments have taken some initiatives, which can be broadly termed as health sector reforms.

Several States have also obtained external assistance to augment their own resources for initiation of health sector reforms in their State. The nature and direction of health sector reforms are specific to each State, with each one being situated at a different juncture in the reform process. Inspite of such divergence, common themes and approaches, objectives and issues can be identified across states. One of the major reform initiatives underway is the Secondary Health System Strengthening Project funded by the World Bank in seven states (Andhra Pradesh, Karnataka, Punjab, West Bengal, Maharashtra, Orissa and Uttar Pradesh). The projects include strengthening FRUs/CHCs and district hospitals so as to improve the availability of emergency care services to patients, to reduce overcrowding at district and tertiary care hospitals, construction works, procurement of equipment, increased availability of ambulances, drugs; improvement in quality of services following skill upgradation training in clinical management, changes in attitudes and behaviour of health care providers; reduction in mismatches in health personnel / infrastructure; improvement in hospital waste management, disease surveillance and response system. All the States have also attempted introduction of user charges for diagnostic and therapeutic services from people above poverty line with varying degree of success. (Planning Commission, Annual Report, 2002-03). Various bi-lateral and multi-lateral agencies are supporting various reform initiatives or have undertaken evaluations and / or reviews of health sector reform in India.

However, there is insufficient, inadequate systematic documentation and analysis of the various aspects of reform. It is essential to assess both progress and problems in implementation of the reforms in each state and to appropriately modify the content and pace of implementation. Such an overview and analysis of all related issues is necessary to provide evidence to policy makers and other stakeholders in terms of the various dimensions and impact of health sector reform. Health sector reforms need to be analyzed in terms of provision of care, managerial function and financial reforms in terms of both demand and supply. Some of the broad areas that need to be covered are decentralization of health care system, public private partnerships, contracting of health services, human resource issues, issues of governance and health care financing, like levying of user charges amongst others. This assumes particular significance in light of the changing role for the government in the health sector today. There is also

a need to identify the content and process of health sector reforms including best and doable initiatives, understand the key stakeholders involved in the reform process and their interests in reforming the health systems, and identify areas where gaps exist in knowledge and / or implementation of reforms, mechanisms for continued monitoring and evaluation during implementation. At the present juncture, there is a need to review the impact of current options and thereafter assess whether they could be implemented differently from the past as well as if required consider introducing substantive changes in different health sector entities and functions.

Recognizing the need for evidence based information about and assessment of various initiatives undertaken as part of the health sector reform process in India, the Bureau of Planning, Ministry of Health & Family Welfare; Government of India has undertaken a review and documentation of health sector reform initiatives in India. As a first step a mailed survey was conducted wherein a questionnaire was sent to Health Secretaries of all the States / UTs with a view to document reform initiatives underway. This was followed by an experience-sharing workshop on September 4-5 2003, organized for the first time by the Ministry of Health & Family Welfare in collaboration with the WHO. The workshop provided a forum for policy makers and other stakeholders to exchange experiences and information on health systems reform, draw lessons and best practices from the experiences of select States. To further augment the information obtained through the state presentations at the workshop and to undertake an in-depth documentation of the content and process of health sector reforms across states, visits to select states were organized. Visits were undertaken to Orissa, Karnataka, Madhya Pradesh and Rajasthan wherein interviews were held with key informants including concerned officers from departments of Health, Family Welfare and Medical Education, bi-lateral and multi-lateral agencies, NGOs and other stakeholders in each state. Secondary information as also copies of government orders were also obtained wherever possible. Simultaneously, interviews / discussions were held with select individuals, agencies and programme officials at the Centre with a view to gather information about various aspects of reform initiatives. The information gathered through these diverse sources – mailed survey, literature review, state presentations, visits to states, interviews with programme officials and others has been compiled into this present document. The draft so prepared was sent to the respective States for feedback prior to its finalization. Comments were also invited from a selected group of reviewers. This document, aimed for policy makers contains information related to genesis, content, process and outcome of health sector reforms across nine states in India. In light of insufficient evidence, no attempt has been made to assess any of the reform initiatives. The next section of the document describes these reform initiatives.

Reform Initiatives across States

Gujarat


BANASKANTHA
KACHCHH
MAHESANA
SABARKANTHA
SURENDRANAGAR
KHEDA
PANCHMAHALS
JAMNAGAR
RAJKOT
BHARUCH
JUNAGADH
SURAT
VALSAD

GUJARAT

The state of Gujarat came into existence on 1st May 1960 and is the seventh largest state in India with an area of around 196,024 sq. km. Located on the Western coast of India, It has the longest coastline in the country of about 1600 km. The geographical areas in Gujarat comprise desert areas of Kutch, arid /semi arid regions of North Gujarat, Saurashtra and Kutch, tribal/ hilly and forested areas of South Gujarat, plain and irrigated areas of Central Gujarat and coastal areas right from South Gujarat to North western part. Administratively, it is made up of 25 districts subdivided into 225 talukas. Gujarat has been in the forefront of industrial and economic activity in the country and has made rapid progress on all fronts be it economic growth, human resource development, or diversifying its industrial base. At the time of its creation, it was largely an agrarian economy with little industrial base. Animal Husbandry and Dairying have played a vital role in the rural economy of Gujarat. Today Gujarat accounts for nearly 19% of the total industrial investments in India and has emerged as a leading industrial State in the country. It is also one of the most urbanized States in India with 37% of the population living in urban areas. Most urban and rural settlements contain a mix of communities, with varying socio-economic levels. Growing industrialisation of the State, increasing needs of the people for better quality of life and the need to cater to the burgeoning trade has put tremendous pressure on the existing infrastructure in the State.

Organization of Health Services & Programmes[1]

Gujarat has a well networked health infrastructure. As in other states, Gujarat implements the various national programmes. The UNFPA funded IPD project is being implemented in the five districts of Surendranagar, Kachchh, Dahod, Sabarkantha and Banaskantha. The European Commission and GOI supported, Sector Investment Programme (SIP) is also being implemented in the state. The Department of Health & Family Welfare, (DoHFW) consists of two main divisions, viz. health and family welfare. It is headed by a Minister of Cabinet rank, while the administrative set up consists of one Principal Secretary. From an administrative perspective, the DoHFW is divided into Directorates / Commissionerates, which include inter-alia, the State AIDS Society, Commissionerate of Health, Directorate of Indian System of Medicine and Directorate of Central Medical Store Office (CMSO). Gujarat also has a number of non-governmental organizations (NGOs) working on health and development activities. Profile of the State of Gujarat is at Annexure.

Reform Initiatives in Gujarat include[2]

(I) Public Private Partnership

A. Entrusting Rural Health, Medical Services & Management of PHC to a Voluntary Organisation

Recognizing that PHCs do not have adequate facilities to provide health services effectively, the low levels of utilization and lack of effective mechanisms to evaluate and monitor their performance, harnessing local support and private initiatives are emerging as an important option to improve the performance of the PHCs under a partnership programme. So far, one PHC and three

[1] Government of Gujarat website - http://www.gujhealth.gov.in

[2] Govt. of Gujarat (2003), Power-point presentation, 'Reforms in Health Services provided by Gujarat State' at the workshop, India 's Health System: Role of Health Sector, Sept. 4-5, 2003, New Delhi, organized by GOI in collaboration with the WHO & Note on 'Reforms in Health Services provided by Gujarat State' by S.K. Nanda

CHCs have been handed over to non-governmental organizations, while nine proposals are under consideration. Under the agreement, the government agreed to finance the entire gamut of PHC services in SEWA-Rural's project area, with the proviso that these services are run on the same pattern as that in the government. SEWA-Rural has been entrusted the responsibility of providing health services in 49 villages of Jhagadia Taluka in Bharuch district[3]. The necessary personnel and equipment required for 30 PHCs in tribal area has also been sanctioned[4]. Through another resolution[5], 14 PHCs have been sanctioned in tribal areas, of which one would be based in Jhagadia. The responsibility for managing the PHC at Jhagadia has been entrusted to SEWA-Rural for a period of ten years. The conditions stipulate that the government would provide grants for the management of the PHC from 1.4.1989. The organization (SEWA) can accept employees from the District Panchayat on deputation. This staff would be under its supervisory control and be governed by the guidelines / conditions outlined in the earlier resolution passed by the Village Panchayat, Bharuch[6] In case the organization seeks to employ its own personnel then it can do so by following the recruitment resolution of either the Government or the District Panchayat provided that the District Health Officer or District Development Officer is a member of the selection committee and the appointment is given in his/her presence. In case SEWA-Rural does not want to manage the PHC or seeks to discontinue its activity, the District Panchayat, Bharuch would take over the management of the same. In such a scenario, the government would consider absorbing the employees who were appointed by the organization provided they satisfy the necessary recruitment criteria. Those not meeting such criteria may be absorbed by the organization in its other activities or relieved from service.

B. Mapping of expertise available for training

With a view to build capacities, health training is planned with the involvement of various institutes of expertise, from both the public and private sector. As part of this initiative, mapping of the expertise available for training in private and non-governmental organizational sectors and to involve them in training (e.g. RCH training, training related to HIV/AIDS) is proposed. Efforts are also underway to involve and enable participation of the community in such training and ensure better sharing of information through community volunteers and National Social Service (NSS) students.

C. Appointment of honoraries & part-time specialists from the private sector

The Government has encouraged private practitioners to provide services in the public sector under "Samaydan scheme". This scheme aims to ease the problem of vacancies of specialists in health and medical services. As part of this scheme, honorary and part-time specialists are being appointed. So far, about 125 such specialists have been appointed. The Government is also actively considering removal of age-eligibility criteria for appointment of doctors in government services.

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[3] As per the resolutions No MIS-1084-917 dt 24.4.1984, Corrigendum No. MIS-1084-917-B dated 2.6.1984 and Resolution No. MIS-1084-2265/867-B dt.10.6.1986.
[4] BUS/1087/257/6-B/dated 15.7.1987
[5] BUD/1087/2571/b dated 13.1.1988
[6] No. 119 dated 30-0683, letter no. DP/734/USAID/86 dated 22.2.1984.

D. Urban Health Care Project

In face of lack of adequate health infrastructure in urban areas, rapidly increasing urban population, absence of basic services like sanitation, drainage, water supply in urban slums, appalling health status and the rapidly increasing costs of health care, the government of Gujarat, has initiated an urban health care project. This project aims to provide primary health care to urban slum population under the public private partnership through community based health volunteers in urban areas. Given the lack of infrastructure in urban areas, towns with less then one lakh population are proposed to be covered under this scheme. The community-based health volunteers would be selected from local areas, will act as link between service providers and community. The towns having either CHC / PHC/ PPU / Urban Family Welfare Centre/ Trust hospital, would monitor their activities. They will be paid monthly honorarium as per the approved scheme. This scheme has been approved by the SRC and would be tried out on a pilot basis.

The project has been submitted to the Government of Gujarat, it seeks to cover 143 Municipal areas. The organizational structure of the Urban Health Cell at the State HQ would comprise of Joint Director (Urban Health), Epidemiologist, administrative officer, head clerk, data entry operator cum assistant and driver. In order to strengthen the regional level, provision would be made for an accounts clerk and data entry operator cum assistant for the purpose of monitoring. Similarly, sanction has been given for posts of 39 health officers in towns having population over 75000; 50 health officers or population between 25,000-75,000; 90 female health workers, one per 25,000 population in urban slums; 1993 female health volunteers, one per 1,000 population in urban slums and 4 urban health centres in the municipal areas where no government or government aided health facility exists. The total estimated cost of the project for 5 years (the exact time period depends on the final approval by the Government of Gujarat) is Rs.1311 lakhs.

E. Contracting out of Information, Education & Communication (IEC) services

With an intention to pool together information available and bring a professional approach to behaviour change communication (BCC), services like IEC are being contracted out. Efforts are also underway to develop partnerships with various stakeholders like pharmaceutical company to ensure wider coverage. The IEC budget from various pharmaceutical companies is pooled together on a common basis and the agencies hired by the private sector are allocated the money for development of IEC material through a special sanction. Such attempts at contracting-out are being tried out with respect to developing IEC material for malaria control especially for early diagnosis of malaria in RCH group, popularizing the use of impregnated bed nets and treatment of complicated malaria. The State Malaria Control Society scrutinizes the offers received and the agencies are selected after a committee has short-listed them.

(II) Decentralization

A. Financial Decentralization for Medicines and Maintenance

Each CHC has a budget allocation of Rs. 1.50 lakh for medicines of which 75 percent directly comes from the Central Medical Stores Office (CMSO) and 25 per cent

is transferred to the facility for buying medicines. The superintendent has the power to spend up to Rs.10,000 on medicines, maintenance and other expenses. In case expenditures exceed Rs.10,000 prior approval is required from the regional office or the DoHFW. Most of the budget grants from the Government are released to the facilities every quarter. However, in practice, a major chunk of the funds is generally released during the months of January and February. For buying medicines or other supplies at the local level, the rate contract system fixed by the government is followed. The CMSO generally provides information about the rate contract. Only under exceptional circumstances the facility supervisors decide to buy from the local market. For maintenance the facilities are generally required to follow the rate contract.

(III) Reforms related to Human Resources

A. Appointment of staff on contractual basis

The RCH programme is being implemented in the State of Gujarat from 1997-98. Funds for various inputs like contractual staff and loans to ANMs for purchase of mopeds are provided by bi-lateral and multi-lateral agencies through the Standing Committee of Voluntary Agencies (SCOVA). The Additional Director (FW) is designated as the Project Director by the Government and is the Member-Secretary of SCOVA. Following a meeting of the State Level Empowerment Committee for RCH-IPD Programme on 10.8.2000, the Additional Director (FW) and Project Director RCH-IPD were empowered to make expenditure upto Rs. 5 lakh per activity per annum, for the planned activities under area projects and also given administrative powers for matters pertaining to contractual staff and staff appointed on deputation in the projects.

B. Reorganization of the entire cadre of Para Medical Ophthalmic Assistant

The cadre of Para Medical Ophthalmic Assistant (PMOA) is being reorganized according to community needs. Taking into consideration the size of the talukas, its population and geographic situation, as well as facilities of communication and transport for patients to reach the facility of care, the cadre has been re-organized to take care of the problem and ensure that PMOAs are provided to 22 talukas/blocks where such posts do not exist. This is being done by relocating PMOA posts in Primary Health Centres to the community health centres to facilitate use of the primary eye care service like refraction, treatment of primary eye care amongst others. All posts of PMOA are now shifted to Community Health Centres and District/ Sub District Hospitals of state with operative facilities for cataract so as to provide the services there. In terms of challenges, there was some minor resistance from people and local leadership due to shifting of the post.

(IV) Changes in Financing Methods

A. Grant-in-aid Institutions as Policy Instrument to Promote Autonomy

The Government has developed an initiative to promote the role of non-profit non-governmental institutions in the health sector. These institutions are recognized as grant-in-aid institutions. There are about 139 such rec-

[7] Department of Health & Family Welfare (2003), "Priorities for Mental Health Sector Development in Gujarat (The Mission Report 2003)" Government of Gujarat

ognized institutions in Gujarat and the Government allocates about Rs. 250 million for the same.[7] The government has developed a set of guidelines for disbursement of grant. The institutions, which are eligible for these grants are required to be noy-for-profit institutions and should be registered under the Societies Registration Act. The Additional Director (Medical Services) in the Commissionerate of Health is overall in charge of these grants. The broad policy guidelines of the Government with respect to these institutions are as follows:

- Gram Panchayat 75 per cent of budget or the real loss whichever is less
- City (Nagarpalika) 70 per cent of budget or the real loss whichever is less
- Municipal Area 60 per cent of budget or the real loss whichever is less

The Chief Medical Health Officer (CMHO) of a district inspects these facilities and approves the budget of these institutions. The institutions are required to give 30 to 40 per cent of free care to poor patients. Grant-in-aid institutions have complete autonomy in staff and investment decisions. These institutions can generate resources from various sources, with the user fee being one source of funds. The institutions can also raise funds through donations and grants from the community and other non-governmental organisations, including the private sector and industry.

(V) Re-organization & re-structuring of existing system

A. Creation of Block Health Office

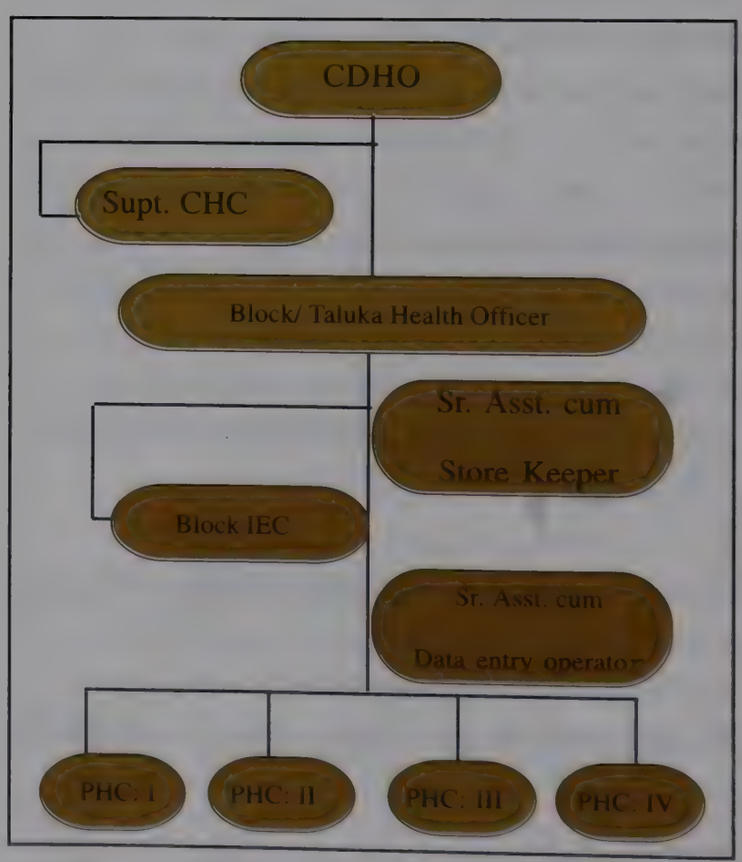
The last twenty years has seen a three-fold increase in numbers of PHCs, but this has not been accompanied by strengthening of the district health organization. Further, while activities related to various schemes and National Health Programmes have been added to the PHCs, these have not been supplemented by giving additional staff at PHC or at the District HQ to supervise the field level activities. In Gujarat, each district, having about 60 primary health centres [PHC], is supervised and controlled by the Chief District Health Officer [CDHO] who is working as a part of local district panchayat administration. This has made it difficult for the district health organization to organize, implement and review the activities carried out by such a large number of PHCs, which are usually located in interior rural/ tribal/ hilly and sometimes in difficult terrains. Furthermore, the GoG has introduced 20% of cutback in filling up the existing sanctioned administrative and other posts. There also exists > 30% turnover per year of medical officers working in rural areas. In many instances the posts of medical officers (MOs) remain vacant for a long period and are then filled up by a freshly recruited MO who needs to be oriented for a large number of activities to be carried out for implementing the various health programmes.

While the GoG has evolved a network of state-run Community Health Centres cum referral hospital [CHC] at taluka head quarters, the referral system has not been is properly established. This has resulted in under utilization of health services at most of the rural institutions. The problem is further compounded by newly emerging diseases like AIDS, Anthrax, Plague, complicated Malaria and other vector borne diseases like Dengue and

Japanese Encephalitis which require crucial and significant day to day monitoring of the field situation. Hence, a need was felt for establish a taluka level health organization, which can take care of primary health care delivery issues.

It was felt that a person at the Taluka/ Block level can help in optimization of time by attending meetings or attending to non-officials who begin delving in matters of public health. Personnel at the block level would function as an 'insulating rod'. S/he would interact and intermediate with all the multi-sectoral agencies and programmes. This has led to the creation of a Block Health Office, which assists District Health Organisation in planning, implementation and review of activities related to PHCs; facilitate supplies of medicines, vaccines and other supplies related to implementation of relevant National Health Programmes; facilitates health-related data flow from the primary health centers; analyzes, communicates and gives feedback to the concerned officials thereby improving quality of delivery of primary health care, as well as enables effective supervision at the Taluka level. This taluka level organization is headed by a Senior scale Medical Officer and supported by ancillary staff like one Block IEC Officer, one Sr. assistant cum stores keeper and one data entry operator. All the health centres of the taluka function under technical supervisory control of CHC Superintendent at taluka level while the CDHO provides district level administrative control to the BHO. The taluka level health organization is indicated in the box below.

This is a zero based budget project with a minimal recurring expenditure; based on re-deployment of existing personnel and re-organisation of existing facilities. For instance, the post of Sr. MO is created by shifting one post of MO from CHC of the district where workload is comparatively less and reduction of the post is not likely to hamper CHC activity. Preference is given to CHC of the same taluka. While physical infrastructure required needs to be spared from the existing CHC or institution attached to the CHC like the PP Unit / old dispensary etc; some site preparation in the form of civil and electrical work is required to operationalise all the activities. This is met through the funds available from the MOHFW. The BHO is responsible for the supplies related to medicines; vaccines and other appliances related to implementation of national health programmes. The project is being implemented in Surat district on a pilot basis.



B. Grouping of Community Health Centres

The Community Health Centres (CHCs) are emerging as a crucial first referral unit with many specialists spreading themselves in the districts and engaging in activities relating to health service delivery. Furthermore, issues relating to the availability of doctor, his / her accessibility, availability of transport facilities, as well as facilities inside the hospital are some of the factors which detract the patients from approaching public sector institutions. Hence, it was decided that attempts would be made at enhancing existing resources by regrouping CHCs and identification of mother CHC as a first referral unit of excellence. Accordingly, the CHCs have been grouped, such that there are 1-2 mother CHCs with at least 4 specialists available in the 50 km area being brought to the selected potential CHCs by rearranging their posts from low performing CHCs, PP units, among others.

C. Delegation of powers to Medical Officers

Most of the physical infrastructure of most hospitals, community health centres (CHC), primary health centres (PHC) and sub-centre (SC) are in dilapidated condition. While funds for repair of these buildings have been released by the State as well as various funding agencies, the Road and Building Department has been unable to cope with small and scattered works. This matter was placed before the State level Empowerment Committee for RCH-IPD Programme, headed by the Chief Secretary to the Government. In a meeting held on 10.8.2000, the Committee resolved to delegate powers to Medical Officers (MOs) for minor/major civil works upto the amount of Rs. 10,000 – 15,000 per work at a time for minor structural repair work or to a maximum of Rs. 25,000 per year. The Committee also delegated powers to the District Reproductive and Child Health (RCH) societies to fix agencies and execute major / minor civil works above Rs. 10,000 with an upper limit of Rs.10 lakh per work per annum. The government is in the process of studying the impact of delegation in relation to government grant, which may also be delegated in future. It also plans to document and evaluate such experiences.

D. Establishment of Emergency Obstetric Care Centres

The GoG has established Emergency Obstetric Care (EOC) centres in tribal and inaccessible areas, aiming to address the high maternal mortality rates. With the use of wireless technology, communication and transport of patients to facility in time is being achieved. This project is being piloted in Santrampur taluka in Panchmahal district with training and networking for early referrals. As a part of this initiative, very high frequency voice communication through wireless is being provided in 32 sub-centers, 8 PHCs, district hospital and mobile vans. Upgraded ambulances having facilities for emergency critical care and newborn care are available at the district hospital. The staff of district hospital and primary health centres are being trained in Emergency obstetric care and the facilities for newborn care and the district hospital are to be upgraded. Rs.50 lakh have been sanctioned under planned activities of the state budget for this initiative.

E. Establishment of Quality Control Circles

Primary health care is provided through a network of community health centres or primary health centres and sub-centres. With a view to improve coverage and en-

hance patient satisfaction, a need was felt to improve the quality of services provided. Hence, a decision was reached to establish quality control circle in one Taluka of Rajkot district under the European Commission supported Sector Investment Programme. Furthermore, the medical and PHC staff of Sabarkantha and Dahod districts, under the United Nations Population Fund (UNFPA) assisted Integrated Population and Developmen(IPD) project were trained to hold awareness sessions about quality amongst the staff at the primary health

F. Establishment of Blood Transfusion Network

Most of the blood banks are in urban areas and are operated privately. Given the high percentage of maternal deaths and the necessity of blood transfusion in provision of Emergency Obstetric Care (EOC), a need was felt to network the blood banks. As a first step, the referral units requiring blood transfusion, storage and collection facilities in the state were identified. It is proposed that a network of blood banks operated by government, trust hospitals and by private owners is established. Blood collection and storage facilities as per Government of India guidelines, will be developed at district hospitals and FRUs. The proposal has been submitted to the Project Management Bureau, GOI formed under the Sector Investment Program and clearance for the same is awaited.

G. Link Couple Scheme

The Sector Reform Cell (SRC) committee has approved the link couple scheme in rural areas. Under this scheme, 10 Couples married during last five years and having an aptitude for social work will be selected from villages where the post of Auxiliary Nurse Midwives (ANMs) post is vacant or the ANM is not staying at the Head Office. They will act as link between service provider and community. Good couples will be rewarded in cash every quarter. The budget for this activity is Rs.10, 000 per primary health centre per year. This scheme has been approved by SRC & is in the planning stage.

H. Development of software for RCH program monitoring

Software for monitoring of the RCH programme has been prepared. Reports are generated as per the format of form no. 9, prescribed under the CNAA. Additional 42 reports are being generated at the district level for facility wise review of the RCH programme. This software has been installed in all the districts and training is being imparted to all staff. Such computer generated reports are now available at the state level.

Annexure

Gujarat

Population	
Population (millions) (2001)[1]	50,596,992
Estimated Urban Population (%) (2001)[2]	37.35
Scheduled Caste population (%) (2001)[1]	7.1
Scheduled Tribes population (%) (2001)[1]	14.8
Vital Statistics	
Life Expectancy at birth (Male) (in years) (1996-2001)[3]	61.53
Life Expectancy at birth (Female) (in years) (1996-2001)[3]	62.77
Total Fertility Rate (per woman) (1999)[3]	3
Sex Ratio (females per 1000 males) (2001)[1]	921
Birth Rate (per 1000 population) (2002)[4]	24.6
Death Rate (per 1000 population) (2002)[4]	7.6
Socio-Economic Profile	
Literacy Rate (total) (%)(2001)[1]	69.97
Net State Domestic Product (2000-01)(P) (Rs. in millions) (at current prices)[5]	921100
Main workers to total population (%) (2001)[3]	33.66
Population Below Poverty Line (%) (1999-2000)[6]	14.1
Water, Environment & Sanitation	
Households having access to safe drinking water (%)(1991)[7]	69.78
Households with no toilet / latrine facility (%) (1998-99)[8]	54.9
Health Status	
Infant Mortality Rate (per 1000 live births) (2002)[3]	60
Deliveries assisted by a health professional (%) (1998-99)[8]	53.5
Health Infrastructure	
Number of Medical College Hospitals (MCH)	NA
Number of District Headquarter Hospital (DHH)	NA
Number of Total Allopathic Hospitals (As on 1.1. 2001)[9]	2528
Number of Community Health Centres (CHC) (As of 31.03.2001)[10]	242
Number of Primary Health Centres (PHC) (as of 31.03.2001)[10]	1001
Number of sub-centres (SC) (As of 31.03.2001)[10]	7274
Health Financing	
Total Health Expenditure as % of total expenditure (Rs. in millions)	NA
Public Expenditure on health (Total) (Rs. in millions) (2000-01)[11]	91892
Per capita public health expenditure (Rs. in millions)	NA

[1]Census of India, 2001
[2]Urban Statistics Handbook, 2000
[3]SRS, RGI
[4]SRS, RGI, 2002
[5]Directorate of Economics & Statistics (As of March 2004)
[6]Planning Commission
[7]Census of India, 1991
[8]NFHS-2
[9]Health Information of India 2002
[10]Health Information of India 2000 & 2001
[11]State Finances, RBI

Himachal Pradesh

HIMACHAL PRADESH

Himachal Pradesh is a land with wide variation in altitudes, ranging from low hills to high mountains, a land studded with lakes, draped with flowing rivers, and where flora and fauna flourish in its forests. This hilly state came into being as a Union Territory on 15 April 1948 and was granted full statehood on 25 January 1971. The State is divided into 3 zones, 12 districts, 51 sub-divisions, 72 blocks, 2922 Gram Panchayats having 16779 villages. The State has an area of 55673 sq. km and constitutes 1.69 percent of India's area. The State has a population of 6,077 with an average density of 109 persons per sq. km The majority of population is rural with most villages having small dwellings with population less than 500. Himachal Pradesh has a large area under tribal belt which covers two districts of Lahaul & Spiti and Kinnaur and Bharmaur and Pangi Development Blocks of Chamba district. Agriculture is the main occupation of the people, contributing 35.87 % towards the State Gross Domestic Product. Apple cultivation is of special significance for the people living in the higher hills of the State.

Organization of Health Services & Programmes[1]

The State has a fairly extensive network of health institutions. In addition to the primary health infrastructure, in terms of SC, PHC and CHC, Himachal has two teaching hospitals, two leprosy hospitals, two TB hospitals, two Medical Colleges and three Dental Colleges. Besides there are Civil Dispensaries, which are run by different departments (Police, University), Boards (HPSEB), Projects like NJPC, BSL, Central Govt. Organizations (Railways, Defence, Cantonment Boards) and semi-government organisations. The State has also shown a keen interest in promoting Indian System of Medicines, especially Ayurveda that is a widely popular, acceptable and affordable system. The private sector is developing rapidly in the state and a number of private hospitals; nursing homes have mushroomed in urban areas like Shimla and other district towns. The State is providing promotive, preventive, curative and rehabilitative health services to people. Specific public health problems are being managed through the implementation of national health programmes like RCH, AIDS, TB, Leprosy, Blindness, Malaria and Iodine Deficiency. The other programmes under implementation include ICDS as well as school health programmes Profile of State of Himachal Pradesh is at Annexure.

Health Sector Reforms in Himachal Pradesh[2]

The genesis of health sector reforms in Himachal Pradesh can be traced to keennesson part of the State Government to reform the Health Sector in Himachal Pradesh as well as the presence of Gesellschaft für Technische Zusammenarbeit (GTZ) and European Commission Programme who are supporting reforms in the health programmes and activities in the state.

The first phase of the GTZ[3] project was implemented in five districts of Chamba, Kangra, Una, Bilaspur, Shimla. In the first phase, January 2000 to December 2002, issues pertaining to developing a decentralized planning approach for cost-effective health services at

[1] Department of Health & Family Welfare, Health Vision 2020 http://hphealth.nic.in/welcome.htm

[2] Govt. of Himachal Pradesh (2003), Power-point presentation on 'Health System Reforms in Himachal Pradesh', at workshop on India's Health System: Role of Health Sector, September 4-5, 2003 New Delhi, organized by GOI in collaboration with the WHO.[3] (Undated) Health Promotion 'Basic Health Programme in Himachal Pradesh', GTZ

community, block and district levels; support to the newly founded "hospital societies "; training of different cadres of health staff in the project area; promotion of the active participation of communities, in particular women, in health activities and support of regional NGOs; developing a health management information system for monitoring and evaluation of offered health services; review of the infrastructure needs and maintenance concepts at primary and secondary levels; ensuring availability of essential drugs of good quality in a primary care setting in combination with Standard Treatment Guidelines and following the State's drug policy were some of the initiatives undertaken. These reform initiatives aim to improve the efficiency of the health sector so that health for all is achieved as early as possible and quality care is made available to the patients.

Reform Initiatives in Himachal Pradesh include:

(I) Public Private Partnership

A. Involving the private sector in service provision

There is provision for reimbursement of expenditure on medical treatment to the Government employees if they undergo treatment in prescribed private hospitals in and outside the State.

B. Contracting out of select services

Three support services in hospitals; viz., scavenging, laundry and diet have been contracted out to the private sector, wherever possible. The responsibility for the security of the health institutions has been entrusted to the Home Guards. The private sector is involved in the service delivery only as far as the National Health Programmes are concerned. There are some hospitals in the State and four Hospitals outside the State where employees of the State Government can seek treatment and reimburse the incurred expenses. Some of the challenges faced, include opposition from government employees and the unions.

(II) Decentralization

A. Decentralization of administrative & financial powers upto the PHC level

By the end of 1999, the administrative and financial powers right up to PHC level has been decentralized. The Block Medical Officers (BMOs) have been given an imprest of Rs. 5,000/- while the Medical Officer In-charge (MO/Ic) of the primary health centres has been given an imprest of Rs. 1,000. Initially, the implementation of this scheme suffered a setback as the capacity of the officers to whom these powers were delegated was not built up to the required level. Capacity building of medical officers in proper utilization of powers is continually being improved along with the RCH refresher courses. However, in practice due to the existing financial crunch, the MO/Ic are unable to full utilize this power, as the Block Medical Officer does not place the funds at their disposal. Inspite of these constraints, MO/Ic have been more confident and are capable of handling these issues at their own level.

B. Role of Panchayati Raj Institutions (PRIs)

The PRIs have been given adequate powers to play a vital role in health related activities. Parivar Kalyan Salahkar Samiti (PARIKAS) have been formed at all the three levels of Panchayati Raj System. The Pradhan of the Gram Panchayat is the President of the Panchayat PARIKAS and the female health worker is the Secretary. The Khand PARIKAS has Chairperson of the Panchayat Samiti as the President and the Block Medical Officer as the Secretary; and the Zila PARIKAS has the Chairperson of the Zila as the President and the Chief Medical Officer as the Secretary.

The functions of the PARIKAS include creating awareness about the National Health Programmes, ensuring people receive full benefit of programmes like RCH, nutrition, clean and potable water, ensuring overall cleanliness, assisting in monitoring ongoing programmes and supervision of health institutions, involvement in resource generation and utilization for CHC and PHC management and welfare. The funds for the Family Health Awareness Camps under HIV/AIDS and those for Mahila Swasthya Sangh activities have been given to PARIKAS so as to ensure more involvement of PRIs in health related activities. Also, sensitization workshops have been held in 10 districts for representatives of PRIs on health and its related programmes. A booklet on PARIKAS and health institutions and health programmes has been published in Hindi. This has been distributed to all the representatives of the PRIs.

(III) Reforms related to Human Resources

A. Appointment of staff on contractual basis

Himachal Pradesh is attempting to appoint health care personnel on contractual appointment. As a part of this process, the first step was to appoint institution-specific doctors. It was successfully done and a three-day pre-placement training was given to these newly appointed Medical Officers. The second step would be to fill 100 posts of doctors and 181 posts of nurses in institutions where there is paucity of staff.

B. Re-organization of human resources from state cadre to district cadre

The state-wise cadre of laboratory technicians; pharmacists; female and male health workers; dais (Birth Attendants) and staff nurses has been converted into district cadre (Workforce Management). Also, all Health and Family Welfare societies have been merged into one at the state and the district levels. Furthermore, the managerial skill up-gradation of senior level officers has been done. The capacity building of Medical Officers to ensure proper utilization of the powers is being done along with the Reproductive and Child Health programme refresher courses. In order to address problems pertaining to PHCs remaining vacant due to non-availability of doctors, institution-specific recruitment of doctors has been done and a three-day pre-placement training to the newly appointed Medical Officers has been given.

C. Promulgation of the Himachal Pradesh Paramedical & Medical Council Bill

An attempt is being made at promulgating the Himachal Pradesh Paramedical & Medical Council Bill 2003. The objective is to maintain the State register of paramedical and medical practitioners and to prescribe a code of ethics for them and to also register the para-clinical establishments.

(IV) Changes in Financing Methods

A. Establishment of Aspatal Kalyan Samiti

With the objective of improving the service provision of a centrally managed health system and to increase efficiency of the existing system, the Government agreed to create Hospital Management & Welfare Societies (Aspatal Kalyan Samiti), at Zonal and District Hospitals by way of a letter issued on August 5, 2000 followed by a Government Order on July 8, 2001. These Samities are registered under the Registration of Societies Act and are set up with an objective of improving system efficiency, service quality; patient satisfaction; enhancing local decisions and initiative of the officers; ensuring accountability at hospital level; enhancing resource utilization and generating resources through community financing and user charges. These societies also seek to provide a degree of autonomy to the health facility, allowing them to raise their own resources through donations, loans, renting out of facilities, and limited hiring of staff, outsourcing of support services and charging for diagnostic services. The user fees are being charged at uniform rates fixed by the government in all the sub-divisional, district and zonal hospitals. The Aspatal Kalyan Samiti has further been extended to Sub-Divisional level Hospitals in 2002. There exists provision for giving seed money to improve such facilities so that they add to resource generation in the hospitals.

The major stakeholders include the community and various non-governmental organizations (NGOs). In some of the hospitals, the NGOs have adopted wards; they provide food to the indoor patients and are involved in improving the infrastructure of the hospitals. The other stakeholders are the Panchayati Raj Institutions (PRIs), district administration, patients and health providers. In terms of the monitoring and evaluation system, monitoring is a regular process. One of the members of the Samiti is a representative of the Audit and Accounts Wing of the Finance Department. The evaluation of the working of these Samities upto the hospitals at Zonal and District level was conducted by Himachal Pradesh Voluntary Health Association (HPVHA). The recommendations of the report are in the process of being implemented.

Primary health care, Emergency services, National Disease Control Programmes as also the entire treatment for families living below poverty line is provided absolutely free. To avail of free treatment, families below the poverty line are required to carry an Integrated Rural Development Progamme (IRDP) card/certificate with them; or the treating doctor needs to be satisfied that the patient actually belongs to the BPL category. The user fees so collected are not deposited in the government treasury but are spent on the welfare of the hospital and the patients.

Over the years there have been successes and lessons have been learnt. Initially when the user fees were notified, patients with the ability to pay were charged. However, this was not implemented in totality as the funds were being deposited in the government treasury and hence there was no interest depicted by hospital authorities in the collection of funds. The users too were reluctant to pay charges due to the habit of getting free treatment from a government health institution. Furthermore, the concept of formation of hospital welfare society and subsequent use of funds for welfare of the hospital and patients was a novel concept and initially not palatable to the public sector employees. There was an apprehension that they would be transferred to the Society. Various unions also opposed the implementation of user fees. This could be resolved only after long deliberation with them. An important lesson learnt through this experience is that prior to initiation of any reforms, all stakeholders should be taken into confidence after a series of discussions with them.

Inspite of such constraints, gradually the effect of these reform measures could be seen in 2002-03. While there was improvement in all the hospitals across the State, these were more remarkable when there were creative and dedicated person in-charge of hospitals. There has also been a change in the people's attitude towards implementation of user fees who have now accepted the user fees.

(V) Re-organization & re-structuring of existing system

A. Functional integration of ISM&H with DoH & DoFW

Functional integration of the Department of Indian Systems of Medicine and Homeopathy and the Department of Health & Family Welfare has been done for the purposes of implementation of the Reproductive and Child Health Programme and other National programmes. The same has been notified.[4] As per this, the territorial jurisdiction of all Government Ayurvedic Dispensaries (GADs) has been delineated on the pattern of PHCs i.e. villages to be covered, population etc. In places where a GAD is located — and where there is some allopathic institution i.e. Sub-centre/PHC/CD — delineation of the area is not undertaken.

This process was streamlined in 2002-03 by putting into practice a defined methodology wherein District Ayurveda Officers attend monthly meetings of the Chief Medical Officers (CMOs); the CMOs allocate targets to the District Ayurveda Officers in preventive and National Health Programmes. Meetings of sub-divisional Ayurveda Officers and Block Medical Officers are held for determining targets for CHCs and PHCs; Officers have been appointed in both the Directorates to solve the problems, if any. The training of Ayurveda officers in National Health Programmes is likely to be undertaken in Health and Family Welfare Department, subject to availability of funds.

[4] Government of Himachal Pradesh Notification, No.HFW-A(F)9-1/99,dated 25 November 1999

B. Notification of service norms & revision of nomenclature for health institutions

Steps have been taken towards rationalization of health institutions by revising nomenclature of the health institutions in the State. Service norms for various health institutions have been notified with an aim to pave the way for "care of a patient and the level at which he would be looked after". Attempts are underway at re-structuring the cadre of Medical Officers in the service of the Directorate of Health and Family Welfare.

The 139 Civil Dispensaries functioning in the Rural Areas of the state were involved in dispensing medicines. These were brought to the mainstream of providing preventive and promotive health care besides attending to curative nature of work. It was a first step towards rationalization of health institutions with staff being mentioned for each category of institutions. The revised nomenclature of the Health Institutions in the State is as under:

a. Civil Dispensaries (except urban) and all PHCs as PHC.

b. All CHCs as CHC.

With an objective of meeting needs of clients, ensuring their satisfaction, attaining highest levels of professional efficiency and optimum utilization of scare resources, services norms have been set as a part of the reform process in the Health Department. Fixing of norms for manpower, services, equipment, facilities, buildings etc. is being undertaken. It is believed that norm setting for services will result in defining service mix at three levels of delivery, in establishing referral system, which will enable strengthening of secondary care system, adequate utilization of primary health care system and provide enhanced support and technical guidance to primary health care system and reduce the load on the already overburdened tertiary care facilities. The types of services under different specialities to be provided at different levels of facility have been identified.

Annexure

Profile of Himachal Pradesh

Population	
Population (millions) (2001)[1]	6,077,248
Estimated Urban Population (%) (2001)[2]	9.79
Scheduled Caste population (%) (2001)[1]	24.7
Scheduled Tribes population (%) (2001)[1]	4
Vital Statistics	
Life Expectancy at birth (Male) (in years) (1996-2001)[3]	NA
Life Expectancy at birth (Female) (in years) (1996-2001)[3]	NA
Total Fertility Rate (per woman) (1999)[3]	2.4
Sex Ratio (females per 1000 males) (2001)[1]	970
Birth Rate (per 1000 population) (2002)[4]	20.7
Death Rate (per 1000 population) (2002)[4]	7.5
Socio-Economic Profile	
Literacy Rate (total) (%)(2001)[1]	77.13
Net State Domestic Product (2000-01)(P) (Rs. in millions) (at current prices)[5]	120230
Main workers to total population (%) (2001)[3]	32.36
Population Below Poverty Line (%) (1999-2000)[6]	7.6
Water, Environment & Sanitation	
Households having access to safe drinking water (%)(1991)[7]	77.34
Households with no toilet / latrine facility (%) (1998-99)[8]	73
Health Status	
Infant Mortality Rate (per 1000 live births) (2002)[3]	58
Deliveries assisted by a health professional (%) (1998-99)[8]	40.2
Health Infrastructure	
Number of Medical College Hospitals (MCH)	NA
Number of District Headquarter Hospital (DHH)	NA
Number of Total Allopathic Hospitals (As on 1.1. 2001) [9]	89
Number of Community Health Centres (CHC) (As of 31.03.2001) [10]	65
Number of Primary Health Centres (PHC) (as of 31.03.2001) [10]	302
Number of sub-centres (SC) (As of 31.03.2001) [10]	2069
Health Financing	
Total Health Expenditure as % of total expenditure (Rs. in millions) (2002-03)	4.83
Public Expenditure on health (Total) (Rs. in millions) (2002-03)[11]	29545.33
Per capita public health expenditure (Rs. in millions)	NA

[1]Census of India, 2001
[2]Urban Statistics Handbook, 2000
[3]SRS, RGI
[4]SRS, RGI, 2002
[5]Directorate of Economics & Statistics (As of March 2004)
[6]Planning Commission
[7]Census of India, 1991
[8]NFHS-2
[9]Health Information of India 2002
[10]Health Information of India 2000 & 2001
[11]Health at a Glance, Health & Family Welfare Dept, 2003

Karnataka


BIDAR
GULBARGA
BIJAPUR
BAGALKOT
BELGAUM
RAICHUR
KOPPAL
DHARWAD
GADAG
BELLARY
UTTAR KANNADA
HAVERI
DAVANGERE
CHITRADURGA
SHIMOGA
UDUPI
CHIKMAGALUR
TUMKUR
KOLAR
HASSAN
DAKSHIN KANNADA
MANDYA
KODAGU
MYSORE
CHAMARAJNAGAR

KARNATAKA

The State of Karnataka is situated in southern part of India. It was formed in 1A956 by joining the state of Old Mysore, and its bordering areas where Kannada was spoken. Each of these territories had been under a different administrative system, so each had different levels of development. This is one of the significant reasons for the variation in development and infrastructure across the state. However after 1956 the state was brought uAAnder one administration and there has been an effort to improve services in the less developed areas. Today, Karnataka has a population of around 53 million people (Census 2001). The state has four natural regions, with each having its distinctive characteristics. Karnataka is India's second most arid state. Statewide figures mask significant disparities: parts of Karnataka are quite developed; others, especially in the north, are backward. Administratively, the state is divided into 27 districts. Today, the state is best known for its software industry. Biotechnology is gradually emerging as a new area. Its capital, Bangalore, also called the Electronics city is one of the fastest growing cities in Asia and is home to industries like aircraft-building, telecommunication, aeronautics and machine manufacture.

Organization of Health Services & Programmes

Karnataka has developed a widespread network of health services. The state is following the national pattern of three-tier centres and sub-centres. It also has a large number of NGOs/ voluntary organizations involved in service delivery, community health and development, provision of health infrastructure through the primary health centres, health units, community health training, research, advocacy and networking. It is also implementing various national programmes like Malaria, Leprosy, Tuberculosis, Blindness and AIDS. In fact, Karnataka was one of the first states to start a District Blindness Control Society (DBCS) in 1990, with support from DANIDA. Since the early 1970's the state has negotiated and received various grants and loans from international funding agencies. The projects currently underway include, India Population project VIII (IPP-VIII), India Population project IX (IPP-IX), Karnataka Health System Development Project (KHSDP), Organisation of Petroleum Exporting Countries Fund for International Development (OPEC), Kreditanstalt fur Wiederaufbau (KfW), Reproductive & Child Health (RCH), Revised National Tuberculosis Control Programme (RNTCP), National AIDS Control Programme (NACP), National Leprosy Elimination Programme (NLEP), National Programme for control of blindness (DANPCB) now NPCB – K, which are implemented through the Government and Directorate of Health and Family Welfare Services. In addition UNICEF has provided project support to different health related sectors including Child Development and Nutrition; Water and Environmental Sanitation; Education; Child Protection; Communications and Strategic Monitoring[1]. While gains in terms of health status have been made in Karnataka, the continuing high levels of poverty, under-nutrition, morbidity and mortality contribute to the challenges faced by the health sector. Access and equity also remain a challenge. Profile of the State of Karnataka is at Annexure.

[1]Narayan Ravi (2001), Review of Externally Aided Projects in the Context of their Integration into the Health Service Delivery in Karnataka, CMH Working Paper Series, WG 6:8

Reform Initiatives in Karnataka

Over the last few years, the Government of Karnataka has initiated several processes to create a facilitative environment and bring about a balanced growth of the health sector. With the intent of improving the public health care system in the state, the Chief Minister set up a 13 member Task Force[2] on Health & Family Welfare in December 1999. The Task Force composition included eminent persons in various fields with the Project Administrator of the Karnataka Health System Development Project serving as the Member-Secretary. The Task Force was required to make recommendations regarding improvements necessary in the management and administration of the Department of Health and Family Welfare as well as to monitor the impact of the recommendations, especially in the initial stages of implementation.

As part of its functioning, the Task Force formed a number of sub-groups; launched a series of research studies; met representatives of the various government departments, voluntary organizations, elected representatives of the public, the press, consumer groups, corporate bodies, private sector hospitals; and invited comments / feedback from the general public. In April 2000, the Task Force submitted an interim report[3] making a number of recommendations. These related to filling up the vacancies of doctors, laboratory technicians and ANMs; increasing the allotment of essential medicines for the PHCs, providing the services of Lady Medical Officers at all PHCs, setting up ISM&H wings in the existing district / taluka hospitals, involving tertiary hospitals in the private sector for providing training to the government doctors amongst others.

The Task Force submitted the final report in April 2001. While corruption was not the only issue highlighted, it topped the list with 12 other crosscutting themes that went far beyond medicine and public health framework. This included neglect of public health, distortions of primary health care, lack of focus on equity, widening gap between policy intent and implementation, decline in ethical values in the professional and health system level, neglect of human resource development, increasing cultural gap between providers and consumers and growing apathy and cynicism in the health care system.

Given its wide mandate, the recommendations of the Task Force can be arranged under 22 themes. The specific recommendations relates among others, to (a) re-organization of the Directorate with a view to streamlining the operations, (b) creation of a separate cadre of public health specialists, (c) mainstreaming of the ISM&H doctors for primary health care, (d) creation of an integrated set up at the State level for planning and monitoring, (e) rationalizing the job responsibilities of field functionaries, (f) decentralization of administrative and financial powers, (g) rational use of infrastructure, (h) role of the PRIs in the day-to-day management of facilities and services, and (i) training, capacity building and skill development. The implementation of many of the recommendations has

[2] GO No. HFW 545 CGM 99, Bangalore, Dated 14-12-1999 & GO No.HFW 545 CGM 99 BangaloreDt.20.1.2000; Notification No. DFAR 133 CAS 2000 dated 6.3.2000.

[3] Government of Karnataka, (2001) "Karnataka Towards Equity, Quality and Integrity in Health, Final Report of the Task Force on Health & Family Welfare", GoK

been initiated under the guidance of an implementation committee. The Task Force also developed the Draft Karnataka State Integrated Health Policy. The Department of Health had wide-ranging discussions on this through a workshop and a series of meetings in-house and with different departments. With minor modifications, this was adopted by the higher committee for health and then by the Cabinet.

Karnataka Health System Development Project

The Karnataka Health System Development Project (KHSDP) was set up in 1996 with a view to improve the secondary level of health care in Karnataka. The project, supported by the World Bank, had an outlay of Rs 546 crore spread over a period of six years. The project sought to bring about improvement in the performance and quality of health care services at the sub-district and district levels, narrowing current coverage gaps and improving efficiency. Major components included improvement of the institutional policy framework, strengthening implementation capacity, development of a surveillance system, extension and renovation of all secondary level hospitals, improvement of their clinical effectiveness and establishment of a properly functioning referral system. Some of the initiatives undertaken as part of this project, include renovation and expansion in 201 secondary care hospitals, increasing the number of beds available in these hospitals, establishment of a comprehensive HMIS connecting all districts under implementation and establishment of an engineering wing to ensure speedy execution of the civil construction programme.

[4] Ltr. No. HFW; COMN:22:2000-01, Dated 25/05/2000 from the Commissioner, Health & Family Welfare Services, Bangalore on setting up of a Project Preparation Committee for preparation of a Comprehensive Health and Population Project proposal for World bank assistance.

Integrated Health, Nutrition and Family Welfare Services[4]

The State has also initiated work towards commencing the Integrated Health, Nutrition and Family Welfare Services Development Project[5] with the assistance of the World Bank. Through this project, the state government aims to improve the health status and access to health care of its citizens with special attention and care for the marginalized and vulnerable sections of society and to redress regional disparities. The project seeks to support infrastructural requirements at the PHCs, CHCs, training centres, a new office complex at State Headquarters for programme managerial staff and a regional drug quality testing laboratory. It also supports purchase of equipment and maintenance, medicinal drugs, vaccines, consumables and mobility requirements, in order to make primary health care effective. Specific interventions have been developed for primary health care and public health. The project also proposes to strengthen partnerships amongst the public, voluntary and private sector through training, continuing education, health personnel planning and management with a focus on implementation of programme components, monitoring, evaluation and feedback systems.

Reform Initiatives in Karnataka include[6-7]

[5] Govt. of Karnataka (2002), "Karnataka Integrated Health, Nutrition and Family Welfare Services Development Project", Project Proposal, Department of Health & Family Welfare, GoK, March 2002

[6] GoK (2003), Response to the Questionnaire on Health Sector Reforms from GOI, Directorate of Health Services.

[7] Govt. of India & EC (2001), "Reform Initiatives under the State Health Systems projects Part-1: Karnataka", ECTA Situational Analysis 2001/ 24, Department of Family Welfare, Govt. of India and European Commission.

(I) Public Private Partnership

It was felt that that convergence of private sector interests and public sector goals would best be brought about by seeking a partnership. Hence, initiatives in public-private partnership were undertaken, with a view to enable optimization of resources such as humanpower, hospital buildings, and medical equipment amongst others. The nature of public private partnerships include contracting out of non-clinical services, management of bio-medical waste, supply of diet to hospitals, outsourcing of clinical services to private institutions, handing over of OPEC hospital to Apollo hospital, involvement of NGOs in leprosy work and hiring services of private anaesthetists in face of their acute shortage within the government. In cases where the government has entered into a partnership with a private partner, a Memorandum of Understanding (MOU) is drawn. As per this document, a governing council comprising of eleven members, six from government and five from the private partner manage this partnership. Further, 40-60 % beds are reserved for general ward patients or patients below poverty line while the remaining beds are categorized as special or deluxe wards at the discretion of the private partner. It is stipulated that no general ward patient will be turned back for non-availability of beds in the general ward and they would be charged concessional tariff not exceeding cost of consumables, materials and drugs. Furthermore, the private partner would solely be responsible for equipping, maintaining and running the hospital and shall make available to the hospital facility funds to meet any emergent situation arising out of natural calamities.

A. Government – NGO Partnership in Primary Health Care

Another form of partnership pertains to handing over of PHCs to NGOs or private medical colleges for maintenance. Presently, around 31 PHCs have been handed over in this manner. This scheme was applicable to all private medical colleges and non-governmental organizations, fulfilling certain conditions and trusts sponsored by reputed corporate bodies with proven managerial capacities. A set procedure is followed for evaluating and selecting the organizations. The DME or CEO of the Zilla Panchayat first verifies the proposals received, which are then chosen by a selection committee.

In terms of management of the partnership, the Medical College / NGO / Trust is fully responsible for providing all personnel. It is stipulated that all the personnel employed at the least would meet the standard staffing pattern. The medical college / NGO / trust is also responsible for fixing the remuneration of its employees. The amount that is charged to patients for diagnosis, treatment, drugs or for any other purpose has to be in accordance with the government policy. Further, these partners are responsible for the implementation of all, National and State Health and Family Welfare programmes.

The existing assets of the PHCs are handed over to the partner agency; who is also responsible for the maintenance of assets with the stipulation that at the end of the partnership, the same would be returned to the government in a proper condition. The partner is

free to make any additions to fixed assets and is responsible for ensuring adequate stocks of all essential drugs. Financial support from the government in the form of reimbursement of remuneration subject to a maximum of 75 percent of salary is payable to the government staff. Reimbursement of water and electricity charges is subject to a maximum of Rs. 1,500 per month while Rs.25,000 per annum is paid towards contingencies and maintenance of buildings. The budget for drugs is based on the scale determined by the government. The funds are released as grant-in-aid once in a quarter. The District Health & Family Welfare Officer undertakes the monitoring of the working of the PHC. The PHC is entrusted to the partner for a period of five years subject to review and confirmation. The government retains powers to give directions to the agency, in public interest and may terminate the contract for violation of conditions of contract by the agency, after due enquiry into such violations.

One of the NGOs involved in a partnership with the government is the Karuna Trust, established in 1980, working with Soliga tribals in the B.R. Hills, Yelandure Taluka. Its programmes include education, health, community organization, revitalization of traditional medicines, bio-diversity conservation, and sustainable agriculture, rehabilitation of displaced tribals, low cost housing, social forestry, tribal cooperatives and promotion of appropriate technology. The Trust has assumed responsibility for running of the Gumballi PHC in Yelandur Taluka.

On the basis of a dialogue with the people of the PHC area, the recommendations of the Gram Panchayat, Taluka Panchayat and the Zilla Panchayat members and on receipt of application to and subsequent approval from the ZP Health Committee, passing of a resolution by the Zilla Panchayat, the application was forwarded first to the Director Health & Family Welfare, then to Secretary, Health & Family Welfare and lastly to the Project Steering Committee of the IPP-9. Thereafter, the GoK handed over the Gumballi PHC and associated three sub centres over to the Karuna Trust in 1996. A Committee consisting of Secretary, Health & Family Welfare, Project Director IPP-9 and the Director, Health & Family Welfare are responsible for monitoring the partnership.

In terms of implementation, the Government makes available to Karuna Trust, 90 percent of salaries under the state budget, Rs. 5000 as administrative expenses and Rs. 50,000 per annum for drugs from the IPP-9 funds. The Karuna Trust on its part, appoints the required staff, including medical officer, pharmacist, lab technician, first division clerk (FDC), staff under Group D category, ANMs (Auxilary Nurse/Midwife) and male health workers at the Gumballi PHC. All the National Health Programmes are integrated in the PHC activities. Equitable distribution of primary health services is assured by ensuring access of health services to the poor and the marginalized, especially SC and ST communities by special efforts like Yellow Card schemes. As the PHC completed five years of service under Karuna Trust, an evaluation team from the government of Karnataka visited the PHC and the sub centres. They identified some constraints and problems like non-availability of supervisory level of workers like LHV and senior health inspector, as they have not been sanctioned and the non-availability of disposable dai's delivery kits and anti snake venom.

B. Handing over of the OPEC assisted Rajiv Gandhi super-speciality hospital to Apollo group as a joint venture

In face of the difficulty in appointing specialists to the hi-tech hospital, the State Government decided to run the OPEC-assisted Rajiv Gandhi Memorial Hospital as a joint venture in partnership with a private agency. In case of the OPEC-assisted Rajiv Gandhi Hospital, more than 1,000 nurses were required to maintain the 350-bed hospital, technicians to handle the sophisticated equipment and hundreds of Group 'D' staff to maintain the hospital were needed. However, the Government was not in a position to appoint the required staff. Hence, tenders were invited from experienced private agencies in the medical field. Six agencies, including the Apollo Group of Hospitals, had participated in the tendering process. A three member panel, comprising the Health Secretary, Project Director, KHSDP and the Health Commissioner, was appointed to go through the tenders in detail. Based on the perusal, a decision was taken to run the hospital as a joint venture along with the Apollo Group.

C. Contracting-out of services

As part of the World Bank-supported KHSDP, contracting out of support services and other non-clinical services is used as a means for ensuring maintenance of a facility. The scheme was designed in view of the unsatisfactory level of maintenance of facility (structures and non-medical equipment) and services by the Public Works Department and Group D staff. The scheme was initially implemented in 32 hospitals (which had been re-commissioned during December 1997 and March 2000). The department has also been contracting out a set of non-clinical services to 82 secondary level hospitals. The range of services contracted includes cleaning of the building and its maintenance, diet, security and waste management. Contracts for outsourcing of services are drawn after a competitive bidding process, with payments being made on a monthly basis, subject to satisfactory performance. The government is no longer recruiting class IV (unskilled labor), and plans to expand the scheme. Furthermore, 30 percent of group 'D' positions are being kept vacant. The existing class IV staff are either transferred or retrained as ambulance or operating theatre assistants. Overall, the contract payments have been less than salaries previously paid to staff to perform the same tasks. In terms of challenges faced, there have been instances wherein, presence of unreliable contractors has led to non-payment of wages to the workers. The scheme was evaluated in April 2000 in half of the facilities where it was in operation. The study endorsed the soundness of the concept but noted the need for improvement on several fronts. For instance, it was noted that one of the basic stipulations – that the vacancy in Group D staff should be at least 50 percent of the sanctioned strength, was not met in some cases. Also, at times the contracts were awarded even while the refurbishment or construction or installation had not been completed. Most importantly, the evaluation underlined the lack of capacity (at the State level) in designing the contracts and highlighted the need to impart management skills to the hospital administrators to facilitate proper supervision of the contractors' work. In other words, it brought out the need to strengthen the scheme in terms of better legal, managerial and administrative inputs.

D. ISO Certification for District Hospitals[8]

The Karnataka Health System Development project embarked on the ISO certification process in January 2002 for 6 district hospitals in 3 services viz. blood bank, maternity services and equipment maintenance. An initial assessment study was carried out at six sites by the consultants. Thereafter, the systematic scheme for ISO processes ensued with the preparation of assessment report, inception report and draft Quality Systems Procedures (QSPs) to be adopted for these three services. These were prepared in close association with all the stakeholders.

After the finalization of QSPs, review of documents and an ISO awareness seminar, the implementation of QSPs began in August 2002. The first phase of the Internal Quality Audit was carried out by IIQ Systems Pvt. Ltd in September 2002. This was followed by identification of a final certification body, which was done by the British Standards Institution (BSI) and meeting of the management representatives. The second phase of the Internal Quality Audit ensued thereafter wherein another meeting of the management representatives was held and the relevant equipment was calibrated by December 2002. A final Management Representative's (MR's) meeting with the 6 DMRs' was held in February 2003. This led to the commencement of the final certification process by the BSI India Pvt. Ltd, which was completed by March 2003. As part of the follow up activities after the certification, six-monthly continued surveillance audits (CSA) are undertaken by the BSI. It is envisaged that this process would continue till February 2006. Simultaneously, an up gradation certification is being sought from the BSI to move from ISO 9002/1994 to ISO 9001/2000. The funds for these activities were available from the KHSDP till March 2004. Thereafter, the Directorate of Health & Family Welfare would extend support till March 2006.

(II) Decentralization

A. Decentralization in health sector

The State of Karnataka for over three decades is engaged in promoting PRIs at the grass root level. In 1970s, this took the form of Gram Panchayats and Taluk Development Boards. In 1983, Karnataka Zilla Parishads, Taluk Panchayat Samithis, Mandal Panchayats and Nyaya Panchayats Act came into existence, which provided for the establishment of Zilla Parishads and Group or Mandal Panchayats. Karnataka was the first state to establish a three-tier system fully in consonance with the 73rd Constitutional Amendment in May 1993 and conducted Gram Panchayat elections in December 1993. The Karnataka Panchayat Raj Act, 1993 also fully provided for the devolution of all the 29 subjects listed in the 11th Schedule of the 73rd Constitutional Amendment. The 1993 Act also provides for reservations for women and weaker sections as per the 73rd Constitutional Amendment, namely, 33 per cent for women and 33 per cent for other backward classes and for SC/ST in proportion to their population. This reservation applies both for the election of members and chairpersons of the Panchayat raj bodies.

The Government of Karnataka (GoK) constituted a working group on decentralization, which submitted its report in March 2002. Based on the recommendations of this report, the GoK has circulated a bill to amend the existing panchayat law of 1993. The 73rd Amendment

[8] Write upon ISO Certification for District Hospitals.

had given sufficient elbowroom to state legislatures to fashion their state laws to best suit their objective realities. In the area of decentralization in health, various initiatives attempted across the state include decentralization of user charges, appointment of doctors on a contract basis, decentralization of non-clinical services. Furthermore, all the National Health Programmes like Malaria, Filaria, Leprosy and TB have been decentralized and control has been given to the Zilla Panchayat and Taluk Panchayat.

(III) Reforms related to Human Resources

A. Appointments on a contractual basis

Appointment of doctors and technical staff is undertaken on a contract basis. For instance, the appointment of personnel at the block level under the RNTCP programme is done on a contractual basis. The other forms of contracting include (i) deputy commissioners being authorized to appoint (a) specialists from the private sector on honorary basis, (b) doctors on contract basis in rural areas as well (c) retired medical professionals on contract basis; (ii) the empanelment of specialists from the private sector in government facilities and (iii) hiring of the services of anaesthetists from the private sector for government facilities.

(IV) Changes in Financing Methods

A. User Fees

The Government of Karnataka had issued an order in 1988 prescribing the user charges for an identified range of services. The scale of fees has also been specified. The order provided exemption to poor patients with green cards under the Public Distribution System, being the means to check eligibility. However, collections were quite insignificant as these were required to be deposited in the treasury. Following a study to assess the willingness of the people to pay for the services in government hospitals, a revised schedule of charges for various services / facilities was formulated. The study also recommended that user charges be made compulsory for all except for the 'below-poverty-line' category with a proviso that there would be a method to identify the poor. It also recommended that adequate financial powers be granted to the administrative medical officer (the officer in-charge) of government hospitals for better maintenance of the hospital. In 1995, as part of the KHSDP, the government established a District Development Fund and assigned the district-level health committees the responsibility of collecting user charges and re-using the same for maintenance and repair of the hospitals. At the District level, BHO and District Surgeon serve as Secretary and Member Secretary of the committee. At the Taluk level, the Taluk Health Officer and ADMO of the General Hospital serve as the Secretary and Member Secretary respectively. The user charges are collected at all hospitals with the amount being kept in the respective district for the use of hospital development. The amount collected is utilized for all basic facilities; minor repair of equipment and civil work, for meeting contingency expenditure, purchase of X-ray and emergency drugs. Presently, the rates are in the process of being revised. In terms of challenges faced, there was initial resistance by public, with a demand for free treatment. The initial protest and resistance from the people reduced with the public becoming accustomed to the same.

B. Health Insurance

The State of Karnataka has attempted innovations in the area of health insurance[9]. The Ministry of Health and Family Welfare, Directorate of Health Services and UNDP in partnership with Karuna Trust, Centre for Population Dynamics and National Insurance Co. Ltd has undertaken work in the area of community health financing, with the objective of developing and testing a model of Community Health Financing suited to the rural community. Other objectives include exposing communities to the scope of health insurance, developing a system for the interface with the organized insurance sector; increasing access to public medical care by rural poor and lower income groups; ensuring equitable distribution of medical care through prepaid insurance; enhancing use of primary healthcare facilities; enhancing awareness of the need for preventive health care and involving area specific community based organizations such as Self Help Groups (SHGs), Village Development Committees (VDCs), Anganwadi workers (AWWs), Panchayati Raji Institutions (PRIs) and Co-operative societies.

This scheme is being implemented through two models. For instance, in Narsipur Taluka, the Karuna Trust organizes as well as manages the scheme while in the Bailhongal Taluka, the official health personnel organize and manage the scheme under the supervision of the Chief Executive Officer of the Zilla Panchayat. The Community Health Insurance scheme is oriented towards the poor, the family and the community constitutes the unit of membership. The scheme is mainly run as part of micro-credit financing for outpatient care through the SHGs. A premium of Rs. 30 per person per annum entails an individual to a health insurance cover of Rs. 2,500. This cover includes all cases of hospitalization at public health facilities. Additionally, Rs. 50 per day is given directly to the hospital for drugs while Rs. 50 per day is given to the patient to compensate for wage loss. The scheme is fully subsidized for BPL SC/ST population and partially for the BPL non-SC/ST population. The APL population cannot avail of any subsidies. For the purpose of implementation, a revolving fund has been established at the health institution to ensure that claims are settled immediately. The social workers deputed at the health centre along with the field staff engage in active case finding; marketing of the scheme, documentation and claim settlement. Cases referred to any other public health institution are also considered for reimbursement. This scheme does not have any exclusion clauses and is enforced immediately. Another scheme, which is managed by the Yeshasvini Cooperative Farmers Health Care Trust, is the Yeshasvini Health Insurance Scheme (YHIS). This scheme developed by the Narayana Hrudayalaya in association with the Government of Karnataka, was subsequently launched by the state's Co-operative Department on June 1, 2003. The YHIS offers all types of operations on the stomach, brain, gallbladder, spine, bones, kidneys and heart entirely free for 1.7 million farmer's families across the state of Karnataka for a monthly payment of Rs. 5 (Rs 60 per year). The State Government donates Rs 2.50 per head per month. In the first four and a half months, 3,800 patients underwent various operations and 15,800 people underwent free outpatient consultation in the 75 recognized hospitals across the state of Karnataka under this scheme. There were no pre-conditions attached regarding the age or the history of diseases and the only criteria for enrollment of the entire family was that s/he should have been a member of a cooperative society in Karnataka.

[9] Community Health Insurance by UNDP, Karuna Trust, & Centre for Population Dynamics- PowerPoint Presentation.

Annexure

Profile of Karnataka

Population	
Population (millions) (2001)[1]	52,733,958
Estimated Urban Population (%) (2001)[2]	33.98
Scheduled Caste population (%) (2001)[1]	16.2
Scheduled Tribes population (%) (2001)[1]	6.6
Vital Statistics	
Life Expectancy at birth (Male) (in years) (1996-2001)[3]	61.73
Life Expectancy at birth (Female) (in years) (1996-2001)[3]	65.36
Total Fertility Rate (per woman) (1999)[3]	2.5
Sex Ratio (females per 1000 males) (2001)[1]	964
Birth Rate (per 1000 population) (2002)[4]	22
Death Rate (per 1000 population) (2002)[4]	7.2
Socio-Economic Profile	
Literacy Rate (total) (%)(2001)[1]	67.04
Net State Domestic Product (2000-01)(P) (Rs. in millions) (at current prices)[5]	936190
Main workers to total population (%) (2001)[3]	36.71
Population Below Poverty Line (%) (1999-2000)[6]	20
Water, Environment & Sanitation	
Households having access to safe drinking water (%)(1991)[7]	71.68
Households with no toilet / latrine facility (%) (1998-99)[8]	61.4
Health Status	
Infant Mortality Rate (per 1000 live births) (2002)[3]	55
Deliveries assisted by a health professional (%) (1998-99)[8]	59.1
Health Infrastructure	
Number of Medical College Hospitals (MCH)	NA
Number of District Headquarter Hospital (DHH)	NA
Number of Total Allopathic Hospitals (As on 1.1. 2001)[9]	293
Number of Community Health Centres (CHC) (As of 31.03.2001)[10]	249
Number of Primary Health Centres (PHC) (as of 31.03.2001)[10]	1676
Number of sub-centres (SC) (As of 31.03.2001)[10]	8143
Health Financing	
Total Health Expenditure as % of total expenditure (Rs. in millions)	NA
Public Expenditure on health (Total) (Rs. In millions) (2000-01)[11]	100533
Per capita public health expenditure (Rs. in millions)	NA

[1]Census of India, 2001
[2]Urban Statistics Handbook, 2000
[3]SRS, RGI
[4]SRS, RGI, 2002
[5]Directorate of Economics & Statistics (As of March 2004)
[6]Planning Commission
[7]Census of India, 1991
[8]NFHS-2
[9]Health Information of India 2002
[10]Health Information of India 2000 & 2001
[11]State Finances, RBI

Madhya Pradesh

MADHYA PRADESH

Madhya Pradesh was an amalgamation of the pre-independence Central Provinces. On November 1, 1956, the present state was reconstituted. At the time of its inception, it was a predominantly agricultural state with a very large tribal population. The major towns were Gwalior, Indore, Bhopal, Jabalpur and Raipur. The main function of these centres was administrative, military, trading or as junction-points on trade and communication routes. Pockets of industrial growth have emerged in Pithampur, Dewas, Malanpur, Mandideep and on the outskirts of most major towns. Madhya Pradesh has several regional variations. In geographical terms, it can be divided into the Malwa plateau, the Vindhyachal and Satpura ranges, the Sone-Narmada drainage region, the Bastar plateau and the Chhattisgarh plains. There is a clear divide in terms of agriculture between the rice-growing Chhattisgarh belt and the wheat-growing Malwa and Gondwana regions. The State of Chhattisgarh was carved out of Madhya Pradesh on November 1, 2000.

Madhya Pradesh has made remarkable progress in the fields of poverty eradication, control of disease, pestilence and famine, as well as in greater harvesting of its natural and industrial productive assets. However, considerable gaps remain. Madhya Pradesh has a total population of 60.4 million, the rural to urban ratio being approximately 73:27. Scheduled castes and scheduled tribes account for 15.4% and 19.9% respectively of the total population. The state is relatively sparsely populated with an average population density of 196/ sq.km. The state has made impressive advances in literacy in the last decade, with an increase from 44% in 1991 to 64% in 2001. Madhya Pradesh has 45 districts and hence an equal number of elected Zilla Panchayats (ZP). The urban sector falls under the purview of 334 urban local bodies.

Organisation of Health Care Services & Programmes[1]

Health care services in Madhya Pradesh are delivered by both public and private providers covering allopathy and Indian systems of Medicine and Homeopathy. The coverage and staffing of health facilities are determined by the norms laid down by the Government of India. In advent of decentralization, the district is the primary unit responsible for implementation of various programmes and delivery of health care services. As in other states, various national health programmes such as Tuberculosis, Malaria, Leprosy, Blindness and AIDS are being implemented in the state of Madhya Pradesh. However, in case of the RNTCP programme and Malaria control programme, an independent delivery structure has been established. In terms of assistance from bi-lateral and multi-lateral agencies, the Asian Development Bank (ADB) is currently supporting the GoMP with a Public Resource Management loan. Under the programme, earmarked resources totaling Rs 4.5 billion are provided for non-salary recurrent costs and for infrastructure investment in the health sector. It is expected that increased expenditure in health and social sectors will result from the reforms that are supported from this loan. The World Bank supports the implementation of the ICDS programme through the Department of Woman and Child Development. DANIDA has a state specific project and has had a long term involvement in the state through its Area Development Programmes. DANIDA is responsible for a significant share of all the primary health care infrastructure built in the State over the past 20 years.

[1] Govt. of Madhya Pradesh, Department of Health www.mp.nic.in/health/main.htm

It is currently focusing on key areas of systems development, training, IEC, drug and medical supply distribution, and the development of management capacity. The European Commission (EC) is supporting the state in the area of health care reforms. UNICEF and UNFPA provide support to the state through nationally agreed programmes.. British aid is provided through the Department for International Development – DFID. In the short term, the focus of DFID programmes is to achieve a demonstrable impact on health outcomes by promoting a safer physical environment, behaviour change and better access to essential services. In the medium to long term it sees this as a means of addressing deeper systems issues through knowledge generation and dissemination, advocacy and programmes aimed at systems development and sector reform. DFID is also planning to provide support for public enterprise reform, decentralized government, rural livelihoods and public service delivery, including the provision of health services. The GoMP and the donors have now recognized the need to improve donor coordination to ensure that all donor-assisted programmes support a single, government defined health sector strategy.

Reform initiatives in Madhya Pradesh include[2-3]

In the arena of health, as all indicators and data show, Madhya Pradesh has a very long way to go. There exist constraints of a difficult terrain, poor availability of funds in a backward and poor region, lack of medical personnel to adequately service the population, coupled with an under nourished and weak population. With no options to enhance funding in health, a need was felt for change in the delivery systems and strategies in the state. To overcome some of these constraints, the State Government has undertaken some reform initiatives

(I) Decentralization

A. Initiatives in Decentralization

Madhya Pradesh emerged as a leader in decentralized development in the mid-1990s. It was the first state in India to hold elections after the 73rd amendment and to pass its own Decentralization Act. The GoMP strategy to deepen decentralization reform is based on: (1) community empowerment by strengthening village level institutions such as the Gram Sabha; (2) untied grants to the Gram Panchayat (GP) level; (3) improved accountability mechanisms, namely by establishing the people's right to recall local elected officials; and (4) devolving state government powers to Zilla Sarkar (District Planning Committee).

Madhya Pradesh has incorporated provisions of Article 243 of the Constitution through Madhya Pradesh Panchayat Raj and Gram Swaraj Adhiniyam, 1993 for rural areas. According to the Panchyati Raj Act of 1993, the state officially transferred authority and responsibility for policy making and programme implementation in 18 sectors[i], including health to the Zila Panchayat. Urban areas are addressed through Madhya Pradesh Municipalities Act, 1961 and Municipal Corporation Act, 1956, the former for Nagar Panchayats and Municipal Councils and the latter for Municipal Corporations. These acts together with various

[2] Govt. of Madhya Pradesh (undated), "Best Practices in the health sector – Madhya Pradesh", A note, Directorate of Health Services, GoMP.

[3] DoHFW, GoMP (2002), "Medium Term Health Sector Strategy and Situation Analysis, PART 2, Situation Analysis: The Health Sector in Madhya Pradesh", Submitted to the State Department of Health and Family Welfare, Government of Madhya Pradesh by HLSP Consulting Ltd & Management Services Group, June 2002

rules cover various aspects of the functioning of local bodies including constitution, elections, conduct of business, functions, and powers. The Constitutional stipulation of a District Planning Committee (DPC) has been given effect through MP Zila Yojana Adhiniyam, 1995 and its subsequent amendments. However, some of the financial and administrative powers earlier given to the DPC between 1998 to 2000 have been withdrawn and vested with the local bodies or the departments.

Under the M.P. District Planning Committee Act, 1995 and Amendment Act 1999 (Zila Yojana Samiti Adhiniyam), the government has created an institutional framework for district level planning and implementation of all development works.The main objectives/functions of the DPC are to formulate a consolidated development plan for the district prepared by the Panchayats and municipalities in the district, based on local problems/ issues which have been duly assessed by local bodies, as well as to identify local needs and objectives through a district level mapping of resources. It has the power to allot funds available through sectoral programmes within the purview of the DPC and to monitor progress of the plan activities. The DPC has been given powers to provide administrative sanctions for tenders upto Rs 1 crore (subject to certain conditions) and to transfer certain categories of employees (other than Class I officers) within the district. The DPC can also determine allocation of funds within certain sectors. Typically the DPC meets once a month, essentially to approve tenders, review progress on implementation of schemes and facilitate coordination across sectors.

In terms of composition, the DPC is essentially a political body with 80% of its members chosen by and from amongst the members of Zila Panchayat (ZP) and Municipalities in the District in accordance with the rural to urban population ratio. Special members include ZP Head, Minister nominated by the State, who will also act as the Chairman and one nominee by the State. The DC, as Secretary of the DPC is responsible for facilitating meetings of the DPC, preparing records of discussions and communication of all decisions.

On 26th January 2001, the GoMP introduced Gram Swaraj system with a view to further strengthen decentralization. This required that Gram Sabhas are established in every village and have the responsibility for administration of programmes at the village level. The key features relevant to integration of health, water and sanitation and woman and child development services are as under:

- As per the amended Act, the responsibility for provision of health, water and sanitation services was shifted to the Gram Sabha or general body of a revenue or forest village (average population of 600 in MP). The Gram Sabha also has a "Village Fund" with receipts from State/Central schemes, taxes, land revenue and income that the Gram Sabha may raise from other sources.

- The ZP, Janpad Panchayat (JP), GP and Gram Sabha can set up standing committees in order to plan and effectively manage their functions. The Gram Sabha and GP have provisions for constitution of Standing Committees for "Health" and "Education, health and social welfare" respectively. The State Cabinet in a recent review of the functioning of these standing committees has take a decision to have only two com-

mittees in place of earlier eight committees. These new Committee) will look after the functions of all the previous committees.[ii]

- The main functions of the Gram Panchayat include preparation of Annual Development Plans, execution of schemes/works/projects routed through the GP by Central or State government. In order to execute this role, it is provided with grants and a share of state levied taxes and fees. In addition, the GP may levy user charges for services provided by it as well as levy certain taxes.

- The role of the JP is to prepare the annual plans for economic development and social justice (based on plans prepared by GPs).

- The Zilla Panchayat has control over all rural development departments in the district. Its key functions include preparation of annual plans and ensuring co- ordinated implementation of these plans, and evaluation and monitoring the functioning of JPs and GPs in the district.

Hence, Madhya Pradesh has gradually been increasing the involvement of local governments in implementing social sector programs. Decentralization over the years has become the overarching policy framework in the state's vision for development.

B. Extension of Mission Mode to Health Sector – The Rajiv Gandhi Mission on Community Health[4]

The Rajiv Gandhi (RG) Missions were started on 20 August 1994 to address selected goals identified as priorities by the state government. Through these missions, the government sort to unlock the physical and human potential of the state by attending to some selected tasks with a sense of urgency. With this view, four missions were established, viz. RG Shiksha Mission, RG Watershed Mission, RG Food Security Mission and the RG Mission on Community Health. The Missions crafted a model that worked through participatory structures, which generated collective action as well as altered institutional arrangements within the government to generate inter-sectoral action around the identified Mission goals.

The Mission on Community Health which began in 2001 is an effort to rework the public health delivery model from below using the structure of political decentralization. It has recast the model of health action to include action within the health sector and parallel action on key determinants of health like safe water supply, sanitation, nutrition and hygiene education. By building in the public health agenda into an inter-sectoral framework at the district and below-district-level institutions (i.e. into the District Planning Committee to the Village Swastya Samiti), the Mission seeks to create a decentralized model of health care delivery. To do this and to also place the delivery of selected services in a rights-based framework, the Mission has created a Swastya Jeevan Sewa Guarantee Yojana (Health Services Guarantee Scheme) which includes creation of two community health activists in each village, one trained bare foot doctor or Jan Swastya Rakshak (JSR) and another trained dai or birth attendant (TBA) who along with the Angandwadi worker, will serve as effective bridges between the community and the nearest unit of public health delivery. New institutional arrangements like a State Health & District Health

[4] Rajiv Gandhi Missions: Eight Years 1994 – 2002, Report To The People, www.mpindustry.mp.nic.in

Society have been established to plan and implement action for health in an inter-sectoral manner.

A) Swasth Jeevan Sewa Guarantee Yojana (SJSGY)

The Swasth Jeevan Sewa Guarantee Yojana is being implemented since July 2001. It is envisaged that the implementation of the SJSGY will lead to increased control by the community in the management of basic health care, creation of community level skills in basic health care and disease prevention, effective management and utilization of current resources and facilities and augmentation of resources to meet health-related tasks. It also seeks to identify a set of services within the health sector and some key determinants of health like safe drinking water, sanitation and nutrition to be provided within a rights-based framework of a guarantee by the government, which is operationalised at the district, panchayat and village level.

These services include:

- Providing a trained Jan Swasthya Rakshak in every village
- Providing a trained birth attendant in every village.
- Provision of Universal Immunisation.
- Three ante-natal checks for pregnant women.
- Provision of safe drinking water supply.
- Provision of nutrition cover to infants, children aged less than 3, pregnant and lactating women.
- Proper sanitation facility for solid waste management and waste water disposal.

Under SJSGY district-level programme has been put in place for health, built on the basis of collective problem definition through a Peoples' Health Survey which in turn forms the basis of a Village Health Register. Village-level health indicators contained in the Village Health Register when aggregated form the District Community Health Action Plan.

In terms of implementation, the district level institutional arrangement is headed by the Chairperson of the District Government. An implementation committee under the District Collector with the District Health Official as convener has also been established. At the village level, the health committee or Gram Swasthya Samiti serves as the implementation agency. The Gram Sabha has the power to determine the number of members of the standing committee on health[5]. It is stipulated that the Health Committee under the Act elects a President, for a tenure of one year from amongst themselves. The Committee is also required to elect a Secretary by two-third majority, with the proviso that the resident Jan Swasthya Rakshak in the village shall be nominated as Secretary of the Health Committee.

i) Jan Swasthya Rakshak (JSR) and Trained Birth Attendant (TBA)

The Jan Swasthya Rakshak (JSR) Yojana was started on 19th November, 1995 with the dual objective of providing basic health services in the rural areas

[5] The number of members prescribed under the Act is 12 of which fifty percent of the members shall belong to Scheduled Castes, Scheduled Tribes and Other Backward Classes, two third of which shall be from Scheduled Castes, Scheduled Tribes and remaining one third from other Backward Classes. The standing committee on health shall have at least one-third women members.

through trained personnel who can treat minor ailments and with the intent of developing a cadre of people to assist in the implementation of national health programmes. It is proposed that the presence of one JSR is ensured per village excepting those villages where formal health institutions (Sub Health Centre/ Primary Health Centre) are functioning. The JSR is selected by the GP/Gram Sabha and training is organized by SIHFW. The JSR is expected to provide health care in the village for which an appropriate fee is charged. A total of 41757 JSR were to be trained to provide one JSR in each village. Till date, however, more than this number i.e. 49,126 JSRs have been trained. This is because of the decision of the Government that one additional JSR should be provided in those villages where the tribal population is more than 50% of the total village population.

With an objective of filling in the information gap and to strengthen the programme, an independent evaluation of JSR was conducted. The evaluation brought out that the scheme is regarded to be conceptually sound and designed to meet a felt need. Issues like attrition rate in JSRs, the selection procedure, educational status of JSRs, need for better training aids, training management and training curricula, ensuring their link with the public health system and monitoring mechanism, were some of the issues raised. Based on the feedback received certain changes have been incorporated. For instance, it has been ensured that the Gram Sabha plays an active role in the selection of JSRs, the education criterion for JSRs has now been relaxed and preference is being given to candidates from SC and ST communities. The feedback on improving training management, curriculum and its design has been incorporated into the training now being given to JSRs. The evaluation report mentions that "redesigning the scheme with educated involvement of users, analysis of processes, better support systems, and slower pace could provide a viable option for village level primary care. Also there is a need to institute controls including control by users, better training, continuing education and concerted effort on National/ State Health Programmes." Most of these recommendations have been put into effect under the overall umbrella of the SJSGY[6]

Along with JSRs, the State Government has also decided to ensure at least one TBA for each village as part of the Swastya Jeevan Sewa Guarantee Yojana. Of the 52,317 inhabited villages in the State, till date 51,619 TBAs have been trained thus ensuring one TBA in all the villages with a few exception where women are not available for training / two or more small villages have been provided with one TBA.The main objectives of the dai programme is to provide ANC checkups, identify high risk pregnancies and counseling on nutrition and safe delivery; to conduct safe deliveries; to identify danger signs during delivery and appropriate timely referral. So far, 41,928 dais have been trained and another 1466 are under going training.

ii) Development of a Village Health Register and a Village Health Plan

As a village forms the basic unit of planning, needs assessment is undertaken at the village level through a village health register and a health plan is developed. This in turn leads to the development of a district health plan. An attempt was made at putting together a

[6] Govt. of Madhya Pradesh, "Madhya Pradesh Human Development Report 2002', Govt. of Madhya Pradesh

comprehensive data base on the health status of each village through the Peoples Health Survey or the Lok Sampark Abhiyan on Health. This survey helped to capture information on the status of health, health provision and status of determinant services. The information collected was put together in the Village Health Register.[7] The village health registers in turn are utilized to support a plan for Community Health. If required, additional resources are made available through a District Community Health Action Fund, implemented through the system of Gram Swaraj.

To sum, the Mission on Community Health is relatively new. Its larger objective is to strengthen district-level management of health care, create concerted action on health and its determinants and build action for health from below through community health activists. The various missions have benefited from the process of decentralization in the state, they have helped to deepen it and in turn are nourished by it. One of the lessons has been the necessity of developing state specific responses and strategies to address emerging health and development challenges.

B) Constitution of State Health Society & District Health Societies

As a part of the Rajiv Gandhi Mission, the State has constituted a State Health Society under the Chairmanship of the Chief Minister. The aims of this society include providing direction to the health sector; enabling integrated management of all National and Family Welfare Programme; facilitating the implementation of all or any of the programmes / projects supported by external agencies, overseeing the implementation of health policies, development and dissemination of IEC, promoting the involvement of the NGO, voluntary and private sector in health and related programmes, co-ordinating and strengthening disease surveillance, provision of technical support, review and co-ordination of Rogi Kalyan Samiti (RKS) set up for various state level institutions, amongst others.

The by-laws of the society stipulate the composition of the general body, criteria for membership and conditions for termination of membership, the rights, powers and duties accorded to the General Body, the nature of meetings to be held, including the minimum quorum. Similar guidelines are laid down for the functioning of the Executive Committee. The General Body consists of the Chief Minister as the Chairperson, with the Principal Secretary Public Health & Family Welfare acting as the Member Secretary.[8] Commissioner Health and Commissioner Family Welfare are the Joint Member Secretaries, while other members include Director Public Health, Director Medical Services, Mission coordinator RG Missions and two eminent persons in the field of health, nominated by the Chairman.

Similarly, District Health Societies have been constituted in each district for decentralized and convergent planning, resource pooling, implementation and monitoring of health programs at the district level. The District Health Committee is chaired by the Collector and the CMHO is its Secretary. The Committee also includes district officials of Department of Public Health Engineering who

[7] Village Health Register includes information on JSR, Dai, immunisation, ANC, Family Welfare, Malnutrition, Availability of Safe Drinking Water, Ser vice Providers, VHC, Depot Holder, 4 Vital Registrations.

[8] The other members include, Ministers from Department of Health & Family Welfare and Department of Medical Education, Chief Secretary, Principal Secretary from Departments of Finance, Women & Child Development, Public Health Engineeing, Panchayat & Rural Development, Tribal Welfare, Medical Education, School Education, Forest and Public Relations.

look after drinking water and sanitation and Department of Women and Child development, who look after nutrition and women empowerment. Chief Executive Officer, Zila Panchayat is also a member. The District Health Society replaces different societies e.g. District RCH Society, District Leprosy Society, District TB Society, District Aids Control Society etc. so that there is better coordination of activities and rational fund use.

(II) Reforms related to Human Resources

A. Appointment of staff on contractual basis & provision of incentives

While many vacancies exist in rural areas, medical officers are inclined to get their positing in the urban areas. Hence, in order to ensure adequate doctors, the state government has made provision for contractual appointment of medical doctors by framing M.P. Public Health & FW Medical Cadre Contract Service Rules 2002. This initiative has various benefits as it ensures that rural posts are filled quickly. Furthermore, these appointments are done for specific place and for a specific period. Moreover, attractive remuneration is given to the doctors so as to ensure that they work in the rural areas. Under these contract rules, retired MOs who are medically fit are also taken up for service up to the age of 65 years. Currently, the state government is providing incentive to those doctors who have completed three years of service by regularizing them.

B. Course on Midwifery – The Obstetric Care Provider

The State has initiated moves to institute a course on midwifery. A taskforce constituted for the purpose has proposed curriculum and the State is in the process of selecting an institution for running the course. These trained community based obstetric care providers (OCPs) shall have their rural jurisdiction duly defined. They would also charge for their services in accordance with the rates determine by the Gram Panchayats.

C. Integration of ISM Medical Officers for RCH Services

The State has decided to utilize the services of ISM Medical Officers for RCH services. A training module has been developed and 357 ISM medical officers (out of 1407) have been trained.

(III) Changes in Financing Methods

A. Establishment of Rogi Kalyan Samiti [10-11]

In the state of Madhya Pradesh, as in other states, traditionally the delivery of health care has been within the domain of public sector. However, the availability of funds has been grossly inadequate when compared to the requirement. The burgeoning increase in population has stretched the facilities in government run health institutions to the limits, thereby leading policy makers and people to explore avenues for joint ventures to deliver better health care. Parallely, during the last few decades, there have also been isolated efforts at involving the people in augmenting physical infrastructure in government health

[10] Rogi Kalyan Samiti website – www.rogikalyansamiti.com

[11] (Undated), "Rogi Kalyan Samiti: An Innovative Project for the management of public hospitals through community participation in the state of Madhya Pradesh"

institutions. These efforts, however, were based on personal commitment and initiative and therefore could not be sustained. Hence, a debate was put forth to develop a system of sustainable public-private partnership for improved health care in the government sector in Madhya Pradesh through the establishment of RKS

Following a successful experiment with RKS in cleaning and refurbishing of the Maharaja Yashwant Rao Hospital (MYH) at Indore, the state initiated a scheme for citizen involvement in the management of state hospitals and health centres and introduction of user charges. RKS have been formed in all 43 District Hospitals, 53 Civil Hospitals and 228 Community Health Centres. RKS are also functioning in 717 of the total 1194 Primary Health Centres in the State. During the year 2003-04, the collection of the RKS was Rs. 1183.52 lakhs while the expenditure was Rs. 553.69 lakhs.[12]

In terms of its genesis, the plague epidemic which occurred towards the end of 1994 in the town of Surat provided the impetus for this innovative project to improve the public health delivery system in the city of Indore. One of the first places where attention was focused by the then District Collector of Indore, Shri S.R. Mohanty was the MYH Hospital. After an elaborate public discussion on what ailed the system, every aspect and shortcoming of the system was thoroughly diagnosed. The formation and implementation of the concept was headed by the local administration with active support from the general public as well as the locally elected representatives. Furthermore, in response to an appeal made to the people of Indore, donations started pouring in. The 750 bed hospital, along with five other supporting hospitals located in the same campus, was stripped bare. Through a carefully calculated process of admissions and discharge, all the patients were shifted to 12 hospitals situated all over the town, both government and private. The hospital was evacuated, cleaned, refurbished and its facilities vastly improved before reopening it for public use. No government funds were used in the project, which cost a little over Rs. 45lakh. With a view to ensuring a permanency to these changes, it was decided, to

(a) Carry out a scientific reallocation of available space to improve efficiency

(b) Initiate redefinition of administrative responsibilities

(c) Introduce user charges in the hospital to strengthen the resource base

(d) Establish a management structure, known as the Rogi Kalyan Samiti to ensure permanency to the changes.

Around a year after the experiment at the MYH in Indore, the State Government directed other districts to take up similar projects. In the first year, a handful of districts, especially those close to medical colleges adopted the scheme. By 1997-98, almost all the districts in the state had adopted it. All the committees were authorized to levy user charges according to their local conditions while remaining within the broad parameters laid down by the government. After a review of the system in 1999, the government issued instructions that gave sweeping powers to the Samitis. The instructions expanded the objectives

[12]Directorate of Health Services, MP.

as well as the duties of the RKS.

The main objectives and activities of RKS include qualitatively improving the management of the hospitals with community participation, bringing about upgradation of the health institution and modernisation of health facilities, purchase of equipment for institution, ensuring discipline & monitor accountability, provision of assured ambulance services for emergencies and during accidents, establishment of a public private partnership for betterment of the institution, maintenance & expansion of hospital building, development of the unused extra land of the hospital for commercial purposes as per the guidelines of the state government, increasing community participation, organizing training & workshops for staff members, ensuring adequate and safe disposal of hospital wastes, arranging for good quality diet & drugs and stay arrangements for the relatives of the patients, ensuring equity through provision of free treatment to patients below poverty line as well as proper maintenance of the hospital, wards, beds, equipment, cleanliness of premises and monitoring and supervision of the National Health programmes and lastly obtaining donations in cash or kind from the public at large or obtaining loans from banks & financial institutions for development & up-gradation of medical facilities in hospitals.

The RKS is a registered society and has been set up in all medical colleges, district hospitals, and community health centres. It includes people's representative, health officials, local district officials, leading members of the community, representatives of the Indian Medical Association, members of the urban local bodies and Panchayati raj representative as well as leading donors as their members. The composition of the RKS seeks to combine government officials, political leaders, peoples' representatives, donors, professionals and leaders of the community. Rogi Kalyan Samiti at each level has constituted two bodies for its effective functioning, namely, the General Body (GB)[13] and the Executive Committee (EC)[14]. A similar structure and composition comprising of relatively junior officers as notified by the government is replicated for hospitals at the PHC and CHC level, as well as at the tehshil and block level wherein community health centers, civil hospitals and other hospitals are covered.

The General Body is responsible for policy decisions, which in turn would be implemented by Executive Committee. Further, it has the power to amend the objectives, membership and change the rules and regulations of the RKS, authorize the EC for implementation of its functions, delegate financial powers to the EC and approve financial proposals that are beyond the powers of the Executive Committee, review the financial accounts and grant budgetary approval. It is stipulated that the GB meets atleast twice a year; and that its quorum consists of 1/3rd of its members. The EC would implement the decisions taken by the GB, is required to perform its day to day functions, has to meet at least once in two months with a minimum quorum of 50% of its members. It has the authority to raise funds for

[13] The General Body at the district level as per government directives, has the Minister in-charge of the district as the Chairman, with the Chairman of the District Panchayat, the Mayor or Chairman of the Municipal body, the District Collector, the Superintendent of Police, the Chief Medical Officer, one member of the legislative assembly, one senior doctor, the CEO of the district panchayat as well as the municipal body function as members. Additionally, the Executive Engineer PWD, two donors, leaders of the community, Secretary of the Red Cross Society as well as President of the Indian Medical Association serve as members. The Civil Surgeon is the Member Secretary of the RKS at the district level.

[14] The Executive Committee at the district level is headed by the Collector, members include CEO Municipal body as well as CEO District Panchayat, CMO, one senior doctor, one donor and the civil surgeon are members of the Executive Committee.

activities approved by the General Body, including new construction, purchase of equipment, drugs and consumables amongst others; as well as to appoint staff on contractual basis and levy user charges.

The RKS functions mostly as an NGO, has the freedom to determine the quantum of user charges to be levied. Charges are levied for all facilities provided in the hospital including the outdoor patient ticket, pathological tests, indoor beds, specialized treatment and operation amongst others. The Society raises additional funds through donations, loans from financial institutions, grants from government as well as other donor agencies. It also manages and has taken over the management of canteens, rest houses, stands, ambulance services and other facilities within the hospital complex. They allow private organizations offering high tech services like Pathology, MRI, CAT Scan, sonography to set up their units within the hospital premises in return for providing their services at a rate fixed by the RKS. The funds received by the RKS are not deposited in the state exchequer but are available to the executive committee constituted by the RKS.

Each RKS is free to utilize the funds as per its own judgement. The broad guidelines indicate that the funds could be utilized for ensuring regular maintenance, repairs and necessary construction/expansion of the physical facilities in the hospitals; ensuring cleaning, security, hospital waste management, MIS and other services of the hospital through private agencies; providing improved facilities by addition or upgradation of OT complexes; sonography, burn unit; ICCU; pediatric; CAT-scan units; centralized pathological set up amongst others; purchase of equipment, chemicals, furniture and other necessities for efficient running of the hospitalsfurthermore the funds are used for providing improved medical facilities through purchase of modern equipment through the donation received and if required through loans from financial institutions; provision of a better atmosphere, facilities for attendants and ensuring improved medical facilities in general; introduction of appropriate methods of disposal of medical waste and provision of medical care to the poor and needy (e.g persons living below the poverty line, freedom fighters) free of cost on self certification, or to others highly subsidized rates as compared to private hospitals.

In terms of successes and challenges, RKS has now been set up in all the district hospitals and other health institutions in the state. As fallout of the RKS experience, medical colleges have been granted autonomy and their management has been handed over to the RKS. The establishment of such society has led to an increasing sense of involvement of the community in management of its own affairs and enabled th em to contribute towards the strengthening of public institutions, brought about improvement in the efficiency of the doctors, helped stem the deterioration in public institutions and enhanced the credibility of the public institutions and led to an increase in the number of patients coming to government hospitals after introduction of user charges. The gradual introduction of user charges for the various ancillary services has ensured availability of services to people at a low cost. Further, there have been almost no protests in the entire state over the introduction of user charges. Some of the challenges which remain include, further developing the RKS in urban areas as well as

focusing on rural areas, ensuring the development of need based planning for the future, capacity building and training of its members, improving the work environment to bring about optimal performance, networking of the centres, issues pertaining to human resource development, development of a strong monitoring system and evaluation of performance, establishing linkages between grants, external financial assistance and borrowing and developing feedback as well as regulatory mechanisms so as to ensure delivery of services at an economical cost to the community. A few lessons learnt bring out the criticality of ensuring regular maintenance and upkeep, beyond the creation of such institutions, the need to regularly review performance, essentiality of ensuring the participation of the public in management of programmes and institutions. While, there has been success in creating a decentralized system, question remains as to how the institutional mechanism of RKS will ensure its sustainability and at the same time meet the health needs of the community.

(IV) Re-organization and re-structuring of existing system

A. Revision of Building Construction Rules

The State of Madhya Pradesh has been plagued by problems relating to lack of adequate health infrastructure. Hence, with a view to address these issues, the following amendments were made to the building construction rules.

- Administrative approval for civil construction up to Rs. 20 lakh can be issued by district health committee (on the condition that the State government has made provision in the budget),
- Decisions pertaining to civil construction upto Rs.20 lakh can be made by the District Health Committees through State PWD/ Housing Board/ Development Authorities.
- The Rogi Kalyan Samitis of district hospitals are competent to undertake civil works up to Rs. 10 lakh.
- The Rogi Kalyan Samiti of Civil Hospital can undertake civil works up to Rs. 5 lakh.
- The Rogi Kalyan Samitis of CHCs & Block level PHCs can undertake civil works up to Rs. 3 lakh.
- The Rogi Kalyan Samitis of Sector PHCs can undertake civil works up to Rs. 2 lakh.
- The construction of sub-health centres up to Rs. 5 lakh can be done by Village Panchayats.

B. Effective Operationalisation of First Referrral Units

The GoMP has initiated development of facility - specific operationalisation plans for all FRUs in the State under the aegis of District health societies. The implementation of operationalisation plans is underway.

(V) Other Policy Initiatives

A. Development of State level policies

The State of Madhya Pradesh has formulated various state policies. These include the Madhya Pradesh Population Policy, Women's Policy, Nutrition Policy and Draft Drugs and Medical Supplies Policy.

The MP Population Policy sets out specific targets for replacement level fertility, IMR and MMR to be achieved by 2011. It seeks to increase the involvement of PRIs, private sector and NGOs to promote people's participation in population stabilisation efforts as well to reorganise management and administration of the family welfare programme to make it efficient. The State Policy on Women formulated in 1995 included goals and action points in different areas of concern. In the realm of health, it reiterated the commitment of the GoMP to improve the physical well-being and survival of women and further listed fifteen action points towards this end. As the earlier policy had set targets to be achieved by 2000, a review was conducted and presently efforts are underway to formulate a new policy.

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[i] Rural Development, Health & Family Welfare, Fisheries, Public health engineering, school education, social welfare, women & child development, agriculture, scheduled castes & scheduled tribe affairs, mineral resources, food & civil supplies, youth & sports, rural industries, dairy & livestock, revenue, social forestry & labour (Madhya Pradesh Panchayat Raj Act, 1993)

[ii] The ZP health committee formed under the PRIs in rural areas was responsible for procurement of medicines & supplies, management of para-medical and administrative staff in the district and disease surveillance amongst its other activities. Technical support to this committee was provided by the CMHO as an Additional CEO and meetings were held once a month. Health committees were required to be established at each level of PRI, namely JP Health Committee (JPHC) at the block level, Gram Panchayat Health Comm ittee (GPHC) at the community-cluster level and the Village Health Committee (VHC) at the community/village level. As part of the ULBs in urban areas, the Health Committee had two permanent health staff within the committee, namely the Health Officer and the Health Inspector. Activities of the health committees of ULBs include sanitation and IEC activities.

Annexure

Profile of Madhya Pradesh

Population	
Population (millions) (2001)[1]	60,385,118
Estimated Urban Population (%) (2001)[2]	26.67
Scheduled Caste population (%) (2001)[1]	15.2
Scheduled Tribes population (%) (2001)[1]	20.3
Vital Statistics	
Life Expectancy at birth (Male) (in years) (1996-2001)[3]	56.83
Life Expectancy at birth (Female) (in years) (1996-2001)[3]	57.21
Total Fertility Rate (per woman) (1999)[3]	3.9
Sex Ratio (females per 1000 males) (2001)[1]	920
Birth Rate (per 1000 population) (2002)[4]	30.3
Death Rate (per 1000 population) (2002)[4]	9.7
Socio-Economic Profile	
Literacy Rate (total) (%)(2001)[1]	64.11
Net State Domestic Product (2000-01)(P) (Rs. in millions) (at current prices)[5]	641150
Main workers to total population (%) (2001)[3]	31.66
Population Below Poverty Line (%) (1999-2000)[6]	37.4
Water, Environment & Sanitation	
Households having access to safe drinking water (%)(1991)[7]	53.41
Households with no toilet / latrine facility (%) (1998-99)[8]	77.8
Health Status	
Infant Mortality Rate (per 1000 live births) (2002)[3]	85
Deliveries assisted by a health professional (%) (1998-99)[8]	29.7
Health Infrastructure	
Number of Medical College Hospitals (MCH)	NA
Number of District Headquarter Hospital (DHH)	NA
Number of Total Allopathic Hospitals (As on 1.1. 2001)[9]	95^
Number of Community Health Centres (CHC) (As of 31.03.2001)[10]	342#
Number of Primary Health Centres (PHC) (as of 31.03.2001)[10]	1690#
Number of sub-centres (SC) (As of 31.03.2001)[10]	11947#
Health Financing	
Total Health Expenditure as % of total expenditure (Rs. in millions)	NA
Public Expenditure on health (Total) (Rs. in millions) (2000-01)[11]	86159
Per capita public health expenditure (Rs. in millions)	NA

^Reduction in is due to non-reporting of Rural Hospitals and exclusion of Chattisgarh
 # Prior to re-organisation of the State

[1]Census of India, 2001
[2]Urban Statistics Handbook, 2000
[3]SRS, RGI
[4]SRS, RGI, 2002
[5]Directorate of Economics & Statistics (As of March 2004)
[6]Planning Commission
[7]Census of India, 1991
[8]NFHS-2
[9]Health Information of India 2002
[10]Health Information of India 2000 & 2001
[11]State Finances, RBI

Orissa

ORISSA

Orissa formed on 1st April 1936, lies on the East coast of India, along the Bay of Bengal. It extends over an area of 155,707 square km. accounting about 4.87% of the total area of India. According to the 2001 census, it has a total population of 36,707million. Orissa is regarded as one of the poorest and least developed states in the country. The demographic composition reveals pre-dominance of tribals, scheduled castes and small peasants. Administratively Orissa has 3 revenue divisions, 30 districts, 58 sub-divisions, 171 tehsils and 314 Community Development Blocks. On the basis of homogeneity, continuity and physiographical characteristics, Orissa has been divided into five major regions : the Orissa Coastal Plain in the east, the Middle Mountainous and Highlands Region, the Central plateaus, the western rolling upholds and the major flood plains.

Agriculture provides employment to 77 % of the total employment of the state with paddy being the major crop. Orissa has an enormous mineral potential with its reserves of iron ore, manganese ore, lime- stone and graphite. However, the recurrent natural calamities like the cyclone, drought, flood coupled with the persistent resource constraint have been the major inhibiting factors for the growth and revival of the economy. The State is gradually building up a sound socio-economic infrastructure for self-sustaining economic growth with equity by way of adoption of new economic reforms and reorientation of district administration through successive Five Year Plans.

Despite gradual improvement in health status over many years, preventable mortality and morbidity in Orissa are high. The root causes of poor health continue to be poverty, social deprivation, low levels of literacy and inefficient health systems and infrastructure for health care and control of diseases, particularly communicable diseases. Socio-cultural inequities and barriers, insufficient assertion and demand for health care, inadequate geographic spread of service outlets and poor quality health care reduce access to and effectiveness of public services.

Organization of Health Services & Health Programmes in Orissa [1-2-3]

The Government of Orissa through numerous programmes in the health sector seeks to provide adequate, qualitative, preventive and curative health care to the people of the State as well as to ensure health care services to all, particularly to the disadvantaged groups like Scheduled Tribes, Scheduled Castes and the backward classes. It also aims to provide affordable quality health care to the people of the State not only through the Allopathic system of medicine but also through the Homeopathic and Ayurvedic systems; to ensure greater access to primary health care by bringing medical institutions as close to the people as possible or through mobile health units. These objectives are met through various programmes and the health infrastructure existing in the state.

Orissa is presently implementing various National Health Programmes such as Tuberculosis, Malaria, Blindness, AIDS, Leprosy and RCH. In addition to this, the DFID has supported various initiatives such as Primary Health Care, Phase III (1997 to 2000); Rehabilitation and Reconstruction in cyclone affected areas (2000-2004)

[1] Almas Ali, D'Souza Ravi & Sekhar Dutta Himanshu (2003), Health Status of Orissa 2003, Draft, Orissa Voluntary Health Association

[2] Profile of Orissa : http://www.osfcindia.com/

[3] Govt. of Orissa, Dept. of Health: http://orissagov.nic.in/health/hlthhome.htm

and strengthening of Sector Development of Health care (2001 onwards) while the UNFPA is implementing the Integrated Population Development (IPD) project and the World Bank is supporting the Secondary and Primary Health Care Project (Health Systems Development Project) (1998-99 to 2004). In 2001, the Government of Orissa initiated a process to develop a medium term health sector strategy and a Health Vision 2010 document, which outlines strategies and points for action for development of the health sector in Orissa. Profile of the State of Orissa is at Annexure.

Genesis of Health Sector Reforms in Orissa[4]

Interest in health sector reform in Orissa began in the mid-1990s. This was propelled by the occurrence of two events, (1) the formation of a Committee of the Orissa Legislature chaired by the Health Minister (called the House Committee) which looked into three important aspects of health care and in 1995-96 recommended, cost recovery through user charges in hospitals, granting of autonomy to be given to district and tertiary hospitals and abolition of private practice by doctors. These recommendations coincided with the evaluation by DFID, which stated, that in order to ensure effective health care delivery, the Government of Orissa needs to.

- Make funds available for maintenance of buildings and equipment
- Make funds available for medicine (i.e. drugs and consumables)
- Make funds available for transport (i.e. mobility) – especially for health care delivery and supervision.

These reports served as an impetus for health sector reforms in Orissa. In the five years or so following these two events, a number of reforms, both large and small, have been introduced in the health sector in Orissa. Some of them relate to changes in administrative and operational systems, some to changes in personnel policies including skill development for better service delivery, and some were aimed at giving a minimum health guarantee to the people.

These reforms were given considerable support through two important, externally funded projects, viz. the Orissa Health and Family Welfare Reform Project and the Orissa Health Systems Development Project.

Orissa Health & Family Welfare Reform Project

After Phase I & II of the DFID supported project, Phase III (1997-2001) was implemented with a project outlay of Rs. 14.55 crore. This project sought to fill the gaps in terms of maintenance of buildings, mobility and medicines with a view to providing quality primary health care at the village level in two demonstration districts of Keonjhar and Bhadrak. It also aimed to identify areas and mechanisms to ensure community participation and to address the health needs of the disadvantaged population, particularly, the needs of women. Under the reforms, petty maintenance has been made the responsibility of Medical Officers and Waste Management in Primary Health Institutions has been introduced. The Zilla Swasthya Samitis (ZSS) or District Health Societies have been made functional and the project activities are implemented through the ZSS. Repair and maintenance of health institutions and assets is also taken up through the ZSS. Provision of adequate quan-

[4] Govt. of Orissa (2003), "Orissa Vision 2010 : A Health Strategy, Orissa State Integrated Health Policy, Strategies & Action Points", Health &Family Welfare Dept., Govt. of Orissa, February 2003

tities of quality drugs in primary health care institutions is being ensured.

Orissa Health System Development Project

The Orissa Health Systems Development Project (OHSDP) is under implementation since September 1998 with the assistance of the World Bank. It seeks to improve health care delivery in selected primary and secondary hospitals in the State; increase efficiency in the allocation and use of health resources and address systemic, broad-based problems faced at the first referral and community levels. Furthermore, it seeks to strengthen systems including overall management, procurement of drugs and equipment, referral, health management information system (HMIS), surveillance of major communicable diseases, health care waste management and equipment management system.

A Policy and Strategic Plannng Unit (PSPU) has been established to provide strategic planning support to the project and to push the health sector reform agenda. The project is managed and implemented by a Project Management Cell (PMC), headed by a Project Director who is responsible for routine project management, monitoring of progress, maintaining flow-of-funds and project account, providing technical guidance and general administration and preparing progress reports. At the district level, the Zilla Swasthya Samiti (the District Health Committee) is responsible for monitoring and supervision of project activities including the collection and distribution of user charges, maintenance of equipment, waste management, training of technical staff, quality assurance and surveillance of major communicable diseases.

Reform Initiatives[5-6-7] include:

(I) Public Private Partnership

A. Handing over PHCs to NGOs

The handing over of PHCs to NGOs was experimentally tried out in two tribal districts as the government was finding it difficult to provide health personnel in some small single doctor PHCs in remote locations. The GoO entered into partnership with a view to ensure provision of better health care to the people in remote areas. Under the agreement, the PHCs were to be managed and run by NGOs. This experiment did not run for very long and the NGOs handed the PHCs back to the government after sometime. An evaluation of the initiative revealed that the terms of reference and modalities of transfer were inadequate and the NGOs did not have the resources and ability to run the institutions. The evaluation report recommended trying out the experiment in more places with suitable modifications. Presently, public private partnerships are being implemented for safe abortion services and social marketing of disposable delivery kit (DDK). Parivar Seva Sangh and Population Services International are being taken as agencies of implementation under the Sector Investment Programme. Also, facilities for 24-hour drug counter have been established by private agencies inside the hospital campus. Presently, discussions are being held between representatives of NGOs and government and terms of reference are being developed with a view to initiate such public-private partnerships.

[5] Govt. of Orissa (2003), Response to Questionnaire of Health Sector Reform from GOI.

[6] Note on Managing Sector Reforms supported by European Commission (Received from the EC office, Dr. S. K. Rath)

[7] Gupta Meena (2002), "State Health Systems: Orissa", Indian Council for Research on International Economic Relations (ICRIER), Working Paper No. 89, November.

B. Outsourcing of cleaning in hospitals

Given the lack of cleanliness in government hospitals, in July 1997, an experiment was carried out wherein the cleaning work of Capital Hospital, Bhubaneshwar, a major hospital, was contracted out to a private agency – viz, Sulabh International at a negotiated price. It was agreed that the existing cleaning staff (i.e. the government employees) would be engaged in other work in the hospital. The state government's finance department required that while no retrenchment need take place, existing vacancies of cleaning staff be abolished and any new vacancies occurring as a result of retirement or death not be filled up. Initially there were some protests from the Class IV employees union, but since no retrenchment of staff was involved, the protests did not gather momentum. The contracting-out of select services has led to proper maintenance of hospitals, proper management of waste and better care for patients and their attendants. Some of the challenges faced included resentment from the regular cleaning staff, non-utilization of existing staff and problems in ensuring timely payment to the agency.

Thereafter, other hospitals also sought to contract out the cleaning services in their institutions. Since funds were a constraint, this could not be done, at once, in a large number of hospitals. However, in September 1998, further contracts were signed with Sulabh International for the cleaning of one ward of the SCB Medical College, Cuttack, and 6 wards of the MKCG Medical College, Berhampur. Subsequently, this was extended to 4 district hospitals. Presently, contracting out is being carried out on an experimental basis in some districts. In addition to this, security services in Capital Hospital, Bhubaneshwar and other such larger hospitals have also been contracted out.

In contracting out of cleaning and sanitation of hospital, the selection of the contractor is made through a tender procedure. Experiences in hospital cleaning and sanitation, solvency of the contractor, availability of assets, location of contractor's office, tax clearance certification, registration number, etc are taken into consideration by the tender committee. This committee is headed by the District Collector (Chairman) and the CDMO or Addl. CDMO or ADMO (PH)as members. Tender notices are published in the newspapers and the Collector of the State is the final authority in selecting the contractor.

Following a recent State Government decision, the costs of cleaning and sanitation are to be made out of the user charges generated through the ZSS. In case of disputes and controversies in selection of the contractors, the matter is to be referred to State Director and Government for final decision. The hospital cleaning and sanitation is supervised by the Hospital superintendent and the payments are passed through the ZSS. It is proposed that catering and laundry services are also contracted out.

(II) Decentralization

A. Initiatives in Decentralization

In the state of Orissa, there has been a move towards decentralization, wherein the districts and the health institutions have been granted the authority to plan, budget and implement its own health programmes. They are also able to generate their own resources, within the

purview of the broad government guidelines. Moreover, financial and administrative powers have been delegated to the district administration and the block health administration. The programme officials opine that in terms of success, lessons and challenges, delegation of financial and administrative power has led to improvement of quality of services to staff like timely payment of entitlements, positioning the right person in right place, better control on sub-ordinate and minimization of workload in the Directorate. However, some challenges remain. The delegation of power to block level has not been supplemented with training of MOs in administrative and financial matters. There is no provision made for attached support staff. Another area, which requires strengthening, is establishment of inter departmental harmony. Another development in the realm of decentralization has been the formation of ZSS.

(i) Formation of Zilla Swasthya Samitis

With the increasing emphasis on decentralization, ZSS were developed as an important district level functionary for implementation of health related programmes and activities. The ZSS was initially formed in 1993 as registered societies in five districts of Orissa, with a view to implement the DFID assisted Area Development Project, Phase II. Subsequently, such societies were formed in all districts to implement the various GOI supported health programmes. Earlier, separate district level societies were established for malaria, tuberculosis, blindness, leprosy and AIDS, wherein each society was operating and implementing specific health programmes under the chairmanship of the District Collector. With a view to reduce the multiplicity of committees and societies at district level, the government issued an order[8] leading to merger of all existing societies into one society- the ZSS and the subsequent modification of by-law of ZSS to this effect. Subsequently, all the CDMOs were asked to dissolve the existing societies in the district and merge them with the ZSS. Also, on merger, the existing assets and liabilities of the merged societies devolved on the ZSS. Autonomy has been given to all hospitals under the jurisdiction of the ZSS / DHH in particular. For large hospitals, the hospital society has been constituted with powers and functions like the ZSS.

The primary objective of ZSS is to provide the Health and Family Welfare Department, with increasing support for effective implementation of its ongoing programme such as population control, reproductive and child health, immunization, school health programme, control of diarrhoeal diseases, control of TB, leprosy, etc. The ZSS acts as a nodal forum for all health and family welfare activities to be undertaken in the district. Over the years, the range of activities to be undertaken by the ZSS has increased to include development and maintenance of health infrastructure, planning and implementation of effective IEC programmes, collection and utilization of user fees for various hospital services operation of ambulances, procurement and distribution of drugs, delivery of various non-clinical services, provision of training to medical, paramedical and non-medical personnel, volunteers amongst others, ensuring community participation through the PRIs, publication of literature relating to health and family welfare programmes, undertaking research on issues related to health and family welfare, amongst others.

The ZSS is a society at the district level registered

[8] GO – No. 18902/ H, dated 23.05.1998

under the Society Registration Act, 1860. As per the recently amended MOU [9] of the ZSS, the District Collector and the District Magistrate are the co-Chairpersons, while the CDMO is the Chief Executive cum Vice-Chairperson. The members of the general body include government officials like the Executive Engineer (R&B) / PWD, ADMO, ADMO (PH) / (Med) / (FW), PD (DRDA), amongst others as well as NGOs, representatives of donor agencies working in the district, etc. Additionally, there are patron members, ex-officio members, nominated and co-opted members. Any individual or institution with an interest in health activities and an aptitude for social work can become a member of the ZSS on request and by application, subject to the approval of the Executive committee.

As a part of the DFID supported health and family welfare reform project, a case study[10] on ZSS was conducted. This study covered four sample districts of Kendrapara, Bolangir, Bhadrak and Jagatsinghpur. It mainly involved discussion with the members of the ZSS, review and verification of relevant documents, collection of available data on achievement and performance of the ZSS. The study recommended a set of strategic measures for functional improvement of the ZSS. These include inter-alia, the essentiality of developing and providing comprehensive operational guidelines for streamlining of bye-laws, consolidation of financial and accounting systems, especially in light of the need for amalgamation of all district level societies; sanctioning of maximum administrative authority to the CDMO as the ZSS activities pertain essentially to health related programmes and projects; need for appointment of full time senior officer to manage the ZSS activities; appropriate orientation and training to the staff, formation of performance monitoring indicators of ZSS, periodic review of the ZSS and need for better inter-sectoral and inter-departmental co-ordination so as to improve its service delivery performance.

(ii) Amalgamation of Zilla Swasthya Samitis

ZSS have been established to manage health care delivery system in the district in a co-ordinated way through involving government, NGO sectors and community. Earlier, besides a Zilla Swasthya Samiti (District Health Society) which had a variety of functions, a number of individual societies had been set up in the districts for each Central or donor funded programme. There were societies for Blindness, Leprosy, TB, Malaria, etc.

The composition of almost all the societies was the same with the District Collector as Chairman, and the Chief District Medical Officer as Member Secretary. Hence, it was felt that such multiple societies should be amalgamated to form a single district health society. This was done in 1998[11] across the whole of Orissa and the amalgamated societies went by the earlier name of the Zilla Swasthya Samitis.

(III) Reforms related to Human Resources

In 1996, as part of a strategic review of the health sector, undertaken by the Govt. of Orissa in partnership with the DFID, 'in-service training of personnel' was identified as one of the lacunae. Hence, reforms to

[9] Memorandum of Association of Zilla Swasthya Samiti, Health & Family Welfare, Govt. of Orissa, No. 15871/H dated 19.05.2003, Bhubaneshwar

[10] Panda Eva, Mishra D.P & Sahoo N (2000), "A case study on evaluation of functional performance of Zilla Swasthya Samitis (ZSS) leading to development of strategies for their functional improvement", Orissa Health & Family Welfare Reform Project, GoO.

[11] GO – No. 33040/HS/BBSR dated 07.08.98 & GO – No. 18902/H dated 23.05.1998

strengthen and improve the capacity of health personnel were introduced. These included:

A. Mandatory pre-PG rural service

In face of the large number of vacancies of doctors in tribal and 'difficult' areas, the lack of adequate success in ensuring the presence of doctors in such areas, absence of rural orientation to the young doctors, an attempt was made to ensure that young doctors were posted to such areas and institutions.

Under this scheme, which was introduced in 1998[12], all over the state of Orissa, 11 districts, to which doctors are generally unwilling to go to and which have consistently had a large number of vacancies, were selected, and health institutions were identified. The entrance examination for the medical post graduate (PG) courses was held one year ahead of the date of admission. Those who qualified were advised about the medical college and the discipline they would get, and thereafter assigned to one of the institutions in the 11 districts. Those who are not already in government employment were given contract appointments and assigned to these districts. Amendments were also made in the Orissa Medical Service Rules so as to make the first posting to rural areas mandatory. The doctors are required to work in these institutions for one whole year, and only after obtaining a certificate regarding completion of the period, are allowed admission into the PG course. The initiative has been extremely successful, ensuring the presence of doctors in difficult and remote areas. One major reason why this initiative has succeeded where others have failed is that the assignment is for a limited period only, and it is linked to something that is highly desired, such as a PG degree.

B. Internship training programme for better community health orientation

In the past, medical interns were given community health training in three training centres (under the control of medical college) and their attached health institutions. They were trained in large groups of 25 or more, got hardly any exposure to real community health problems and the quality of the training was poor with little, or no, hands-on training. Further, the supervision was done entirely by the medical college teachers, who are themselves not very much in touch with community health conditions and developments. So, with an objective of improving the quality of community health training of medical interns, a new scheme was introduced in 2000[13] across the state of Orissa. Under the new scheme, the interns are sent in groups of two and three to community health centres under the control of the CDMOs for a period of three months to be trained in public health activities. They are exposed to real community health situations and get 'hands on' training. They are supervised both by the medical officers in charge of the institutions as well as the medical college teachers.

C. Multi-skilling of health personnel

Given the lack of adequate skilled personnel like laboratory technicians, an attempt was made to utilize the existing personnel like the pharmacists, health workers, ANMs for different activities. Pharmacists and health workers have been trained in microscopy for sputum and blood examination, and deployed in the implementation of the

[12] Govt. of Orissa Resolution No. MEII.IX.30/97/11454/H dated 21/03/1998

[13] Govt. of Orissa Resolution No. MEII.IX.62/2000-42233/H dated 29/11/2000

Revised National Tuberculosis Control Programme (RNTCP) and the malaria programmes. ANMs have been trained as Directly Observed Treatment, Short-course (DOTS) providers and deployed in the RNTCP in addition to their own duties. This is being done since 1998 and is applicable to the entire state of Orissa

D. Short-course training in anaesthesia administration

In face of the shortage of anaesthesia specialists, short course training in anaesthesia administration was introduced in 1999, as a pilot programme with a view to enable doctors in CHCs to administer anaesthesia in emergency obstetric care. Doctors from the field were given 3 months training in anaesthesia administration. However, the numbers trained are, so far, very small. The scheme, which was discontinued, is proposed to be restarted.

E. Appointment of staff on a contractual basis

In face of lack of adequate personnel, Medical Officers (MOs) have been appointed on a contract basis in the vacant posts. These appointments are made after conducting walk in interviews at the district level with due concurrence of the Director of Health Services. Similar appointments are being made for health worker (female), staff nurse and pharmacist as also for support staff like clerks and drivers against the existing vacant posts.

F. Formation of district cadres for paramedics

Prior to the formation of district cadres, most paramedics such as ANMs, nurses, pharmacists, laboratory technicians were employees of the state and were expected to work in any part of the state. They were also subject to transfers from one place to another. As paramedics are mainly low-paid government workers, mostly women, these conditions of service caused considerable hardship and expense. Besides, the workers, who were from the more developed coastal districts were reluctant to go to the remote and unpopular districts and remained on leave on some pretext. Consequently, many posts in these areas remained vacant. Hence, in 1998, a decision was taken to form district cadres for the paramedics.[14] The existing personnel in the state cadre was divided and allotted to different district cadres. Currently, the districts are responsible for all the new recruitments made. During such recruitment, preference is given to candidates belonging to the same district. It was envisaged that this measure would result in better availability of paramedics in difficult areas, less hardship for personnel due to transfers, and consequently better service to the public. This scheme is being implemented in the entire state of Orissa.

(IV) Changes in Financing Methods

A. User Fees

The system of user fees was in existence in Orissa in the government hospitals prior to 1997 for certain items such as accommodation in cabins, use of ambulance, X-ray and few other investigations. The fee was extremely low and only a fraction of the cost or market prices of the corresponding service. Moreover the amount paid went to the government coffers and not to the hospital, hence there was little motivation to collect

[14] Dept. of H&FW, letter no. MSNG-VIIA-3/97/33953/H dated 23/09/1998 and other relevant GOs for various categories of staff

it. However, following the recommendations of a committee constituted by the Orissa Legislative Assembly to review the health system in three medical colleges, the user fees were revised. In keeping with the recommendations of the committee and with a view to generate additional resources to supplement the budgetary allocation, improve and extend the scope of the medical facilities, the Government of Orissa (GoO) passed an order dated 24th June 1997[15], revising the existing user fees and including more items under the purview of user fees such as transportation, accommodation, diagnosis and medical investigations. Initially, these rates were applicable to the three medical colleges, the district headquarter hospitals, the Capital Hospital Bhubaneshwar and the Government Hospital, Rourkela. For the purpose of collection, the State was divided into A, B and C categories, depending on the levels of development and differential rates were levied with lower rates being levied in the less developed and tribal districts. User fees were initially levied for diagnostics, special accommodation and for use of transport (e.g. ambulance, hearse, etc). The user fees were deposited into the accounts of the Zilla Swasthya Samiti (District Health Society) in the case of district hospitals and into the accounts of specially constituted hospital societies in the case of the medical colleges. From this beginning, the user fees initiative has grown and spread.

Presently, user fees are levied in all medical colleges, headquarter and sub-divisional hospitals and some area hospitals for diagnostic purposes like pathology, biochemical, radiological, ultra-sonography, colour doppler, CT scan and other such investigations. In addition to this, some designated hospitals have pay cabins or clinics. Pay clinics have been established on an experimental basis at dental college, Cuttack wherein the treating doctor also gets a percentage of the benefit shared by the government. Further, in medical colleges, facilities for ICU are available on payment as also the ambulance services. User fees are collected from IPD and OPD patients in some headquarter hospitals, so as to involve the community in the development process. In all cases, the money collected as user fees is spent at the point of collection for improvement of the particular institution. The collection of user fees is limited to families above the poverty line (APL). Families below the poverty line (BPL), national health programmes, emergencies and medico-legal cases are exempted from user fees. Furthermore, if necessary, the cost of treatment for the diseases enlisted in the Panchabyadhi Chikitsa Scheme is reimbursed from a fund placed with the ZSS for the patients.

Procedures have also been laid down for collection of user fees and its subsequent expenditure. User fees may be collected from patients on issue of a proper money receipt, which are duly printed on appropriate books. It is also stipulated that separate receipt books are utilized for different types of fees. The daily collection is to be recorded in a cashbook on a daily basis, thereby indicating the collection of fees from different sources. The amount so collected is to be deposited in a saving bank account with a nationalized bank. The books of account are to be maintained by staff with knowledge of accounts and are to be countersigned by the controlling officer. Additionally, a slip book is to be maintained for patients exempted from payment of user fees. Separate

[15] GO – DC & MA I VII 40/97-21908/H dated 24.06.97

registers are required to be maintained for money receipt books, bank deposits and withdrawals, exempted patients.

At the point of initiation of user fees, the government had also decided to form hospital level societies to collect and utilize the funds collected. In 1993, District Health Societies known as ZSS were formed and registered as societies under the Societies Registration Act 1860. These societies were responsible for management of the health care delivery system in a district in a co-ordinated manner. Collection and utilization of user fees for all institutions in the district is one of the responsibilities of the ZSS. The ZSS is also free to decide the method of collection and its subsequent utilization, except for spending on employment of personnel. The funds collected are utilized essentially for the maintenance and improvement of respective hospitals / institutions.

B. Establishment of a State Health and Family Welfare Society

In light of the problems faced with routing of all funds through the budget (i.e. the government system) such as cumbersome withdrawal and accounting procedures, unavailability of funds on time, a method was devised to ensure availability of funding for health care activities as and when required through the establishment of a State Health and Family Welfare Society in 1998, throughout the state of Orissa. With the establishment of the State Society, all non-budgeted funds were received, channelized, and utilized through the Society. To facilitate accounting and to meet the reporting requirements of donors, separate accounts are maintained for each programme. The benefits of having a State Society (and a single society for all the extra-budgetary funds received) were several. Funds could be easily accessed and were available for specific purposes at the time of need; there was flexibility of use; and the funds could be accessed to manage any sudden crisis or contingency.

(V) Re-organization and re-structuring of existing system

A. Centralized Drug Procurement & Distribution System[16-17-18-19]

Orissa introduced reforms in the drug procurement and distribution system, with objectives of ensuring ready availability of good quality drugs and medical consumables at the right time and as per the required quantity in all government health institutions within the limited budget. It also sought to ensure total error free logical based management for activities such as procurement, accounts, quality control and warehouse monitoring.

Prior to 1998, Orissa followed a decentralized system of drug procurement whereby a list of suppliers was short listed and sent to the health institutions annually. The Medical Officers could purchase their medicines from these suppliers. This process was plagued with various problems. The list of drugs ordered often depended upon the prescribing practice of the doctors, the approved list was sent to the CDMOs very late, resulting in hasty purchase of drugs from the nearest supplier and at times non-utilization of the entire fund, unwillingness of suppliers

[16] Tender document for supply of drugs & medical consumables for a period of one year. (Terms & Conditions for Central Purchases of Drugs & Medical Consumables), Office of the Director of Medical Education and Training, Orissa, 2003

[17] PowerPoint presentation on Drug Management Inventory System (DMIS) by Dr. Paty

[18] Govt. of Orissa (2002), Drug Management Policy, Health &Family Welfare Dept.

[19] Note of Health Sector Reforms in Orissa by Dr. Devadasan, dated 09.09.1999

to supply to the remote districts, absence of any quality assurance mechanisms resulting in supply of poor quality drugs. Furthermore, the drugs were purchased as bulk packed and were dispensed as loosely packed in paper packets, payments to suppliers was cumbersome and cost of drugs was high due to small orders and multiple points of payment. Hence, to overcome these problems, a drug policy was instituted from 1998. The key features of the policy were centralized need based procurement of drugs according to the Essential Drug List (EDL), assuring the quality of drugs procured and improving the acceptability of drugs dispensed.

With the introduction of the new centralized procurement system, which was largely borrowed from Tamil Nadu, several changes have been made. Under the new system, the districts are asked to submit a list of their needs every year. Thereafter, this is collated and tenders are invited from reputed suppliers following 'Good Manufacturing Practices (GMP)'. On opening of the tenders, each drug is allotted to a specific supplier, with the stipulation that they would supply the required drugs over a period of one year. The EDL comprising of generic names of drugs is prepared based on the recommendations of the doctors. The drugs are divided into three categories, primary, secondary and tertiary level. Further, the drugs / consumables to be supplied to primary, secondary and tertiary institutions have been specified. Thereafter, orders for the drugs are placed centrally, but supplies are delivered at the district level. Each institution is informed of its entitlement of drugs (by value) and given a passbook. They can make their own selection, constrained only by the essential drug list and overall entitlement.

Thereafter, the supplier provides the drugs to the Central Drug Store, every three months and drugs are distributed to the periphery on a quarterly basis. The various stores like TB store, Public health store and Family Welfare store have been integrated into a single store, thereby ensuring better inventory and efficient utilization of resources. Quality is insisted upon with proper packing and logos, and quality testing of each batch of drug is done through private laboratories prior to payment. The payment of the drugs is centralized and is made only after the receipt of reports from the peripheral institutions and from the quality control laboratories. The total process has been computerized for drug procurement, inventory control and supply of drugs to district level. In all the 30 districts, drug stores have been computerized and transfer of data is done electronically. For the peripheral institutions, passbooks have been supplied to regulate indents as per earmarked allocation of funds. Furthermore, 20% of the drug budget is supplied to the Chief District Medical Officer (CDMO) for purchase of life saving drugs like oxygen, anti snake venom, etc. In terms of implementation structure, a State Drug Management Unit has been formed for Central Drug Procuring and Distribution System under direct supervision of Dy. Director of Medical Store and Director, Medical Education and Training.

Numerous benefits have accrued out of the new system. The EDL in generic names cuts down the purchase of unnecessary drugs, and results in rational drug prescription; bulk purchase, central payment, and adherence to a strict schedule of payment results in economies of scale and value for money. Strip packing has increased the acceptability of the drugs by the public;

quality testing and black listing of substandard drug suppliers has resulted in good quality drugs being supplied. At the same time, a great deal of advocacy was necessary in the initial stages to overcome the vested interest group resistance and the system was stabilized only after a year or so after its initiation.

B. Petty maintenance of health buildings

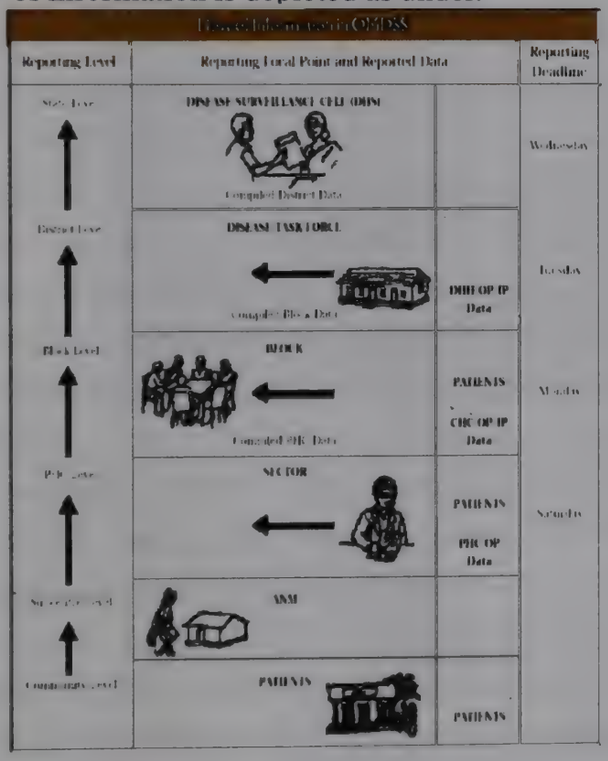
All building maintenance work, including petty and annual maintenance as well as special repairs, have been the responsibility of three government engineering departments - the Works Department (for urban areas), the Urban Development Department (for urban water supply and sanitation), and the Rural Development Department (for rural areas). Since these departments have personnel only at district or at best Block headquarters level, and since health department buildings are scattered far and wide, most of the institutions do not get attended to. Petty repairs, which may cost a few hundred or a few thousand rupees, were almost never taken up on time. The matter, therefore, needed to be addressed. Hence, with a view to ensure timely and proper maintenance of public health institutions, a pilot project was tried out in 100 Block PHCs/ CHCs in 1998.

Under this initiative, in the 100 CHCs/Block PHCs identified in the first year, each Medical Officer in charge was given Rs. 10,000 to take up petty repairs. They were asked to undertake urgent minor repair works following simple procedures and to maintain accounts for the same. The advantage of this new system was that the funds were made available to the occupier of the building, the person actually concerned with, and affected by, the condition of the building. Consequently, it was expected, the repairs would be taken up on time and the quality of the repairs would be better. The initiative has been evaluated and has been found to be useful, but certain gaps in communication need to be addressed. Training has been given to the medical personnel of all the districts on how this programme is to be handled. Changes in procedure are also proposed to ensure proper utilization. The initiative, was initially carried out on a pilot basis for three years with the proviso to extend it to the whole state. The project is continuing since 1998 and 100 Primary Health Care institutions are being covered each year with a total provision of Rs. 10 lakhs. So far, 600 institutions have been covered under the scheme. Besides special provision in the form of minor repair, special repairs are being carried out within the annual provision of Rs. 20-25 lakhs under the State budget.

C. Development of a Multi-Disease Surveillance System[20]

The genesis of the Orissa Multi-disease surveillance system (OMDSS) can be traced to the super-cyclone which occurred on October 29, 1999. Concerned with the possible outbreak of epidemics in the immediate aftermath of the cyclone, a surveillance committee comprising of representatives from the Government of Orissa, Medicines Sans Frontiers (MSF), WHO, OHSDP and NGOs was established on November 11, 1999. This committee was entrusted the responsibility of preparing a strategy for the establishment of an Emergency Epidemiological Surveillance System in the 12 cyclone affected districts. The Department of Health

12 cyclone affected districts. The Department of Health & Family Welfare, approved the protocol developed by the committee and this paved the way for the establishment of the OMDSS. Encouraged by the success of the initiative, the scheme was extended to the entire state in 2001. Presently, data is available from 367 reporting units consisting of the 314 blocks and 53 sub-divisional and district hospitals reporting to the 30 districts in the state. The blocks in turn, receive their weekly data from the sub-centres, PHCs and CHCs. This detailed multi-tiered system of data collection is rooted in the Auxiliary Nurse Midwife (ANM), who monitors the health status of an average of five to six villages. The flow of information is depicted as under.



The weekly analysis and feedback reports are reviewed on a weekly basis by a Technical Committee headed by the JD-PH with the consultants to Orissa Health Systems Development Project (OHSDP) and the WHO, the state epidemiologist and the medical officer in charge of the DSC as members. Minutes of the weekly meetings of the Technical Committee are forwarded to the Director, Health Services, Orissa, all Joint Directors, Health Secretary, WHO India), UNICEF - Orissa and the National Institute of Communicable Disease institutions in the state on a monthly basis. (NICD), Delhi. Formal feedback in the shape of a newsletter is also published and circulated to all government health institutions in the state on a monthly basis. In the present scenario, each district receives weekly data about disease incidence from its remotest subcentres; has a District Task Force –complete with a medical officer, a laboratory technician, a health supervisor, an attendant and a vehicle with a driver - which is ready to rush off to trouble spots at the first sign of an outbreak. There is a state level disease surveillance technical committee meeting every week at the disease surveillance cell to interpret disease patterns and deploy the State task force too, whenever there is a need.

In terms of success and challenges faced, the transmission of data has improved since the initiation of the project, though certain hiccups remain. Presently, data is compiled at each level. However, it is envisaged that with time, districts as well as blocks would be able to engage in data analysis at their respective levels and undertake corrective measures. Also, the system faces challenges relating to transmission of data from the block to the district headquarters, logistics management, ensuring regular data analysis as well as the fact that use of governmental facilities is limited to a small

[20] WHO Country Office India & Govt. of Orissa (2002), "From Disaster to Development: The Orissa Multi-Disease Surveillance System"

include involving the three medical colleges into the system. The success of the OMDSS can be attributed to sensitization and capacity building of all levels of health personnel through hands-on training, co-ordination between the multiple stakeholders, which enabled effective and efficient implementation of this programme, and the methodical manner in which the system was developed.

D. Development of a Pancha Byadhi Chikitsa Scheme (5 Diseases Treatment Scheme)

In face of lack of any clear policy specifying the type and quantum of drugs which would be made available to every person visiting a public health institution, lack of uniformity in dispensing of drugs in public health institutions, patient being asked to purchase drugs from the open market in spite of availability of drugs at the institution, tendency towards over-prescription, high cost of medical care borne by the poor, a need was felt to ensure that every patient approaching a public hospital was guaranteed treatment free for certain major diseases. Hence, a scheme called, 'Pancha Byadhi Chikitsa' (5 Diseases Treatment) was developed in 1999, to cover the whole state of Orissa.

As a first step, an attempt was made to identify the major diseases prevalent in the population, especially amongst the poor. Using indicators of incidence, hospital attendance, cost and ease of treatment, five diseases were identified. These were malaria, leprosy, diarrhoea, acute respiratory infection, and scabies. Thereafter, treatment protocols were developed, estimation was arrived at for the quantum of drugs required, medication was ordered and distributed to all the public healthcare institutions, with instructions to the medical personnel for free provision of the same. A media campaign was also carried out to inform the public about the schemecampaign was also carried out to inform the public about the scheme. The benefits of the scheme were that it created a health entitlement and risk protection guarantee for the poor; it curbed the tendency of doctors to prescribe unthinkingly. It addressed the commonest diseases that affect the largest number of people.

The scheme was started initially for 6 months, and was to be evaluated thereafter. However, it came to a halt after 6 months because of the super cyclone which occurred a few months later and the pre occupation with cyclone restoration work. It is proposed to be re-started shortly. It was clarified that in case any patient was required to purchase medication from the market, the cost of the same would be reimbursed. These prescriptions in turn would be examined during the clinical audit and action would be taken on erring doctors. The scheme created a health entitlement and risk protection guarantee for the poor; it addressed the commonest diseases that affect the largest number of people; and curbed the tendency of doctors to prescribe unthinkingly. The scheme was first started in 1999 experimentally for 6 months. With the super cyclone striking Orissa in late 1999, attention got diverted and the scheme did not get extended. Subsequently, it was restarted as a major state-wide programme in mid 2001.

Profile of Orissa

Population	
Population (millions) (2003)[1]	36.706929
Estimated Urban Population (%) (2001)[2]	14.97
Scheduled Caste population (%) (2001)[1]	16.5
Scheduled Tribes population (%) (2001)[1]	22.1
Vital Statistics	
Life Expectancy at birth (Male) (in years) (1996-2001)[3]	58.52
Life Expectancy at birth (Female) (in years) (1996-2001)[3]	58.07
Total Fertility Rate (per woman) (1999)[3]	2.7
Sex Ratio (females per 1000 males) (2001)[1]	972
Birth Rate (per 1000 population) (2002)[4]	23.1
Death Rate (per 1000 population) (2002)[4]	9.8
Socio-Economic Profile	
Literacy Rate (total) (%) (2001)[1]	63.61
Net State Domestic Product (2000-01)(P) (Rs. in millions) (at current prices)[5]	332760
Main workers to total population (%) (2001)[1]	26.06
Population Below Poverty Line (%) (1999-2000)[6]	47.2
Water, Environment & Sanitation	
Households having access to safe drinking water (%) (1991)[7]	39.07
Households with no toilet / latrine facility (%) (1998-99)[8]	86.5
Health Status	
Infant Mortality Rate (per 1000 live births) (2002)[9]	87
Deliveries assisted by a health professional (%) (1998-99)[8]	33.4
Health Infrastructure	
Number of Medical College Hospitals (MCH)[10]	3
Number of District Headquarter Hospital (DHH)	32
Number of Total Allopathic Hospitals (As on 1.1. 2001)[5]	147
Number of Community Health Centres (CHC) (As of 31.03.2001)[10]	158
Number of Primary Health Centres (PHC) (as of 31.03.2001)[10]	1352
Number of sub-centres (SC) (As of 31.03.2001)[10]	5927
Health Financing	
Total Health Expenditure as % of total expenditure (Rs. in Millions)(2000-01)	2.98
Public Expenditure on health (Total) (Rs. in Millions) (2000-01)[11]	45894
Per capita public health expenditure (Rs. in Millions) (2000-01)[12]	4837

[1]Census of India, 2001
[2]Urban Statistics Handbook, 2000
[3]SRS, RGI
[4]SRS, RGI, 2002
[5]Directorate of Economics & Statistics (As of March 2004)
[6]Planning Commission
[7]Census of India, 1991
[8]NFHS-2
[9]Health Statistics of Orissa, 2002-03
[10]Health Information of India 2000 & 2001
[11]State Finances, RBI
[12] Response from Govt.of Orissa

Punjab

PUNJAB

Punjab meaning "five rivers" is a plains region known as the "breadbasket of the nation" due to the amount of wheat grown in this area. With an area of 50,362 sq. kms, it accounts for 1.5 per cent of the total area of the country and 2.4 per cent of the total population. Agriculture is the main stay of Punjab's economy. The State contributes 80 percent of wheat and 43 percent of rice to the State exchequer. Punjab has the largest tractor population in the country and highest per hectare consumption of fertilizers. It is credited for ushering in the green revolution in the country. A progressive mix of irrigation, fertilizers and high-yielding variety seeds laid the foundation for a fast developing economy; a process, which was further strengthened by agricultural credit societies, rural link roads, village electrification, and a variety of extension services. The intense economic development following the Green Revolution has also given way to a high rate of urbanization. The state also promoted the white revolution, resulting in the highest per capita availability of milk to the people. An agro-based & agro-oriented industrialization is another prominent feature of the state economy. Despite its relatively high income level, the state is noted for considerable out migration to other parts of India as also emigration to several countries.

Organization of Health Services & Programmes[1-2]

During the different five-year plans and annual plans, the Government of Punjab has essentially focused on strengthening the health infrastructure in the form of buildings, machinery, equipment and manpower for primary health care. The Department of Health & Family is the prime provider of public health services - preventive, promotive and curative. The State of Punjab implements various National Health Programmes such as Tuberculosis, Malaria, Blindness, AIDS, Leprosy and RCH. Moreover, school health clinics have been established in all the districts in the state. In order to provide comprehensive oral health care services, emphasis has been laid on prevention of Oral and Dental Diseases by strengthening, restructuring and expending oral health care facilities. The government has also launched a scheme to strengthen the existing emergency health services as well as to improve health care services in towns and surrounding rural areas.

Genesis of Health Sector Reforms in Punjab

The government of Punjab has been concerned with the spiraling cost of health care delivery, specially since the health expenditure is growing at a faster rate than the growth rate of the economy. This is coupled with the demand for an increasing share of resources. In this context, the government is facing the problem of apportioning scarce public resources among competing demands. This is further exacerbated in case of the health sector, given the intangible output of this sector and the heterogeneity of patients seeking assistance. Furthermore, taking note of the lack of basic medical equipment in the district hospitals, sub-divisional hospitals and community health centres, the critical gaps in buildings and inability on part of the government to provide the required diagnostic services, a proposal was prepared in 1995, to revamp the health services. It was felt that the standard of curative health services including diagnostic services

[1] Government of Punjab website - http://www.punjabgovt.nic.in

[2] Govt. of Punjab (2002), 'State Development Report for Punjab 2002', Planning Commission.

in most of District Hospitals, Sub-divisional Hospitals and Community Health Centers in Punjab was a source of inconvenience and dissatisfaction to the general public. Hence, a process of reform was initiated with re-evaluation of the health needs of the community, assessment of the deployable resources in health sector, and analysis and reprioritization of needs and resources.

The World Bank aided "Secondary State Health System Development Project" was consequently, launched in 1995 with a view to providing better secondary healthcare. The assistance received was to the tune of Rs. 438 crore and included a civil component, equipment component and drug packaging. This project aimed to revamp the existing health care facilities, improve their delivery and quality of health care services in the secondary health care hospitals, ensure proper linkages while removing the gaps, ensure access to the health care facilities and improve the efficiency in the allocation and use of health resources. Thus, in terms of thrust areas, the project aimed at renovation of existing buildings, construction of additional hospital buildings, purchase of major / minor medical and other equipment along with vehicles, repair and maintenance of existing equipment, provision of additional manpower and their training and strengthening of information base for policy decisions.

Through the various reform initiatives, efforts are being made to improve the health delivery system in order to ensure that the facilities are accessible to all, especially the poor in the state of Punjab.

Punjab Health Systems Corporation[3]

The implementation of the Secondary Health System project is being carried out through the Punjab Health Systems Corporation (PHSC). The PHSC was created as a statutory Corporation in 1996 vide Punjab Act No.6 of 1996 with the purpose to establish, expand, improve and administer curative and preventive secondary level health care in the State of Punjab. It is a non-commercial statutory Corporation without a revenue stream, and has been funded by way of loans and grants from the World Bank and the State Government.

The specific objectives of the Corporation are to formulate and implement the schemes for the comprehensive development of the dispensaries and hospitals; to construct and maintain dispensaries and hospitals; to implement National Health Programmes as per the directions of the State; to purchase, maintain and allocate quality equipment; to procure, stock and distribute drugs, diet, linen and other consumables; to provide services of specialists and super-specialists in various hospitals; to enter into collaboration for super specialities with health institutions both within the country or abroad to provide better medical care; to receive donations, funds and the like from the general public and institutions from both within and outside India; it also seeks to receive grants or contributions which may be made by the Government on such conditions as it may impose; to plan, construct and maintain commercial complexes, paying wards and providing diagnostic services and treatment on payment basis and to utilize the receipts for the improvement of the hospitals and

[3] Punjab Health System Corporation website - http://www.punjabgovt.nic.in/dcr/phsc.htm

dispensaries; to provide for construction of houses to the employees of the dispensaries and hospitals, to run public utility service and undertake any other activity of commercial nature for the delivery of health care within or without the hospital premises directly or in collaboration with private or voluntary agency on contract basis; to engage specialized agencies or individuals in the relevant disciplines, directly or from external sources for the efficient and expeditious conduct of any of the functions detailed above; and to provide immediate treatment in case of emergency and for un-accompanied patients.

Reform Initiatives include [4-5]

(I) Public Private Partnership

A. Involving the private sector in service provision

The Department of Health & Family Welfare has taken a decision to invite private health care providers to participate or share the operation and maintenance of the select government hospitals. This is proposed to be taken up on a pilot basis, at the 150-bedded Civil Hospital in Amritsar district. The Department has taken up the matter with the Punjab Infrastructure Development Board (PIDB) to explore the modalities for developing a project and a model for the same has been prepared.

The private partners are required to meet its social obligations by way of implementation of Family Welfare Programmes, National Programmes and for provision of access to people below the poverty line and other subsidized categories at the hospital. Apart from this, opportunity would be given to private entrepreneurs to run the super-speciality facilities within the premises of the hospital on commercial basis. The PIDB short-listed three leading health care providers. These were APOLLO Hospital Enterprises, Chennai; Christian Medical College, Ludhiana and Fortis Health Care Limited, New Delhi. The request for proposal was issued. However, given the low level of response, after some modification in the request for proposal, the same are being re-invited.

In the past too, the Government of Punjab (GoP) offered subsidized land to private sector to set up tertiary and super speciality health facilities. The Punjab Urban Development Authority (PUDA) through advertisement in November 1995 invited bids for the allotment of sites for setting-up specialised hospitals in urban estate of SAS Nagar. These bids were invited for six locations having land area of 5 acres and 10 acres. The medical degree qualification or having requisite experience in the field of health care was set as main eligibility criterion. Financial capability in setting up a hospital was also included as one of the important requirements. In response to their advertisement, PUDA received bids from 20 respondents out of which 12 were short-listed. The short-listing was made with view to hold further discussion. Large corporate houses and well known pharmaceutical companies were among the applicants. This initiative did not result into any workable arrangement or collaboration with the private sector. The preference for a particular location by all bidding institutions was cited as the reason for non-acceptance of offers. Furthermore, a number of short-listed organisations did not have adequate experience in health

[4] Govt. of Punjab (2003) "Health Sector Reforms in Punjab" Power-point presentation at the workshop on India's Health System: Role of Health Sector, September 4-5, 2003, New Delhi.

[5] GOI & EC (2001) "Reform Initiatives under State Health Systems Projects: Part-2 (AP, Karnataka, Punjab & West Bengal)", ECTA Situational Analysis 2001/ 26, Department Of Family Welfare, Government of India and European Commission.

and therefore the government was reluctant to offer land at subsidised prices to these organisations. In a few selected cases, land was allotted, but the offer was cancelled later.

In 1997, the Government revived the proposal and issued another advertisement inviting applications for running super-speciality hospitals in five specified urban locations (Ludhiana, Jalandhar, Amritsar, Bhatinda and Patiala). Most of these locations were in areas earmarked for institutional purposes. However, PUDA this time did not provide detailed information on these locations unlike the previous time. In absence of any detailed policy document about the present initiative, the offer was made through an advertisement, which suggested that final allotment of land area would be based on applicant's requirements and preferences.

The revived initiative specified thirteen super-speciality services for which the private participation was invited from institutions in India or Non-Resident Indians. The total capital costs were envisaged to be about Rs. 500 million or more, without accounting for the cost of land. This time the conditions for applying were made more stringent with only those having relevant experience in super-speciality areas being allowed to set-up the facility. The government also laid a condition that those applying should have at least 10 years of experience in the relevant field and have established super-speciality/multi super-speciality hospital of international repute. The offer provided the scope for collaborations suggesting that any applicant interested in setting up health facility but not having past experience in health could have collaboration or affiliation with a recognized medical centre or hospital. The government agreed to offer land for this project at rates ranging from Rs. 1,350 to Rs. 2,060 per square yard depending on the urban estate. This involved subsidies ranging from 40 to 60 per cent. The cost of land was to be paid either in lump-sum or installments. One of the options offered included, setting-up super-speciality centre by having joint venture with the government. Under this option, the cost of land would form the government's contribution towards equity capital in the proposed joint venture. The other conditions included setting-up of proposed super-speciality centre within three years period and use of land for only providing medical services.

The response to this initiative was very poor. Only five applicants evinced interest in setting-up medical facilities. A high minimum investment requirement was seen as the reason for such a poor response. The responses were from two Non-Resident Indian doctors who formed separate consortiums abroad and submitted bid application. The other applicants were big business houses, one of them proposing collaboration with well-known Apollo group having hospital chain in the country. The department, however, did not issue any guidelines to interested institutions describing the process nor did it provide any opportunity to clarify any questions arising in the process of submitting the bids. The advertisement had not described the process of short-listing of the institutions and criteria for allotment of land sites. None of the organizations, who had participated in previous bid, responded to the revived initiative of the government. Besides the stringent conditions of the department for bidding under the new proposed arrangement, respondents to previous advertisement did not find any major perceptible

shift in the policy and process of implementing the proposed initiative. The experience also suggests that earlier invitation had attracted more of local institutions having specific preference for a particular region[6]

B. Outsourcing of services

The Punjab government has begun outsourcing of services in secondary level hospitals. The services relating to security, dental services, sanitation and ambulance services have already been contracted out. These policies for outsourcing of clinical and non-clinical services have been adopted in view of the instruction issued by State government in Finance Department.[7] This policy calls for outsourcing hospital services, health care extension services, diagnostic services amongst others to reputed professional service providers on the basis of monitorable performance criteria so as to ensure a high quality efficiency and standard of services at reasonable cost. It is proposed that diagnostic services, medical waste disposable services, cash collection services, computerization services and maintenance services would also be gradually outsourced.

Presently, the following services have been outsourced. These include engagement of personnel like anaesthesioloigst, dentist, radiologist, radiographer, staff nurses and laboratory technician; security services; sanitation services and ambulance services. Other specialities like ENT, skin, psychiatry, physiotherapy, ophthalmology have also been outsourced. Non-clinical services like diagnostics, X-ray and scanning, collection, transportation and disposal of medical waste services; cash collection; computerization; medical & other equipment maintenance and building maintenance services (air conditioners, tube-well, sub-stations, plumbing, sewerage and electrical) too have been outsourced. The Department has also agreed in principle for not making any fresh permanent recruitment, exception would be made in case of need based appointments, which would be on contract basis. These include posts funded by Government of India; posts in autonomous bodies; posts required as per statute for regulation and posts required to provide basic minimum health services.

(II) Decentralization

A. Initiatives in Decentralization[i]

The 73rd Constitutional Amendment Act, 1992 has given the mandate to establish a three-tier structure of the Panchayati Raj Institutions (PRIs) namely, the Gram Panchayat, Panchayat Samiti and Zilla Parishad, enabling them to assume the role of self-governing institutions at micro-levels of administration for decentralized planning and management. The emphasis is on constituting a Gram Sabha for each village for exercising powers and performing the functions provided in the 11th Schedule under Section 243G. Further 29 subjects have been exclusively transferred to the PRIs for micro-planning and implementation, for economic development with social justice.

The Department of Health & Family Welfare has decided to handover all the Subsidiary Health Centres and Sub-Centres to PRIs. The Department has prepared a schedule of financial powers, administrative powers to be transferred at each level of institution at the level of Zilla Parishad, Panchayat Samiti and Gram Panchayat along with time frame. This schedule has been

[6] Bhat Ramesh (1999), 'Public-private partnerships in health sector: issues and prospects', Second revised draft: May 1999, IIM-A

[7] Vide I.D. No 8/148/2000-4FE2/2628, dated 22.3.2001

communicated to Department of Rural Development and Panchayat. It is proposed that all services would be delegated to PRIs in a phased manner.

As per the decision taken by Council of Ministers on the memorandum brought by the Rural Development and Panchayats Department; funds, functions and functionaries of Department of Health and Family Welfare have been transferred to Panchayati Raj Institutions and requisite notifications in compliance to the decision taken by Council of Ministers have been issued.

(III) Changes in Financing Methods

A. User Fees

As part of the World Bank project there has been a thrust on implementation of the user charges at the rates adopted by the State government. It has been emphasized that the principle of implementing the user charges needs to be made more rigorous for both inpatient and outpatient diagnostic and treatment services in hospitals. The State government is charging user charges as per notification.[8] Initially, user charges were implemented category wise. However, in October 2000, the PHSC further rationalized these charges for the secondary level hospitals by abolishing discretions and slab systems and in some categories enhanced the same. With effect from 1.9.2002, with the approval of the State government, apart from yellow card holders, the PHSC has decided to provide free treatment to poor deserving patients equivalent to 2.5% of the collections. These exemptions are allowed by the hospital in-charge in consultation with the doctor attending the patients after looking into the designed parameters.

To improve the quality of health services, a need was felt to suitably revise the user charges so as to fully recover the direct operation and maintenance costs of these services in a phased manner over a period of five years. It was also decided that to begin with, the manpower cost and one time capital expenditure on some of these services would continue to be met out of the Government's budget. Additional revenue to be so generated would be exclusively utilized to improve the quality of services. In future, the revision of user charges would be indexed to major cost components. The Department also proposed other measures to mobilize resources especially through user charges. These include:

i) Extending the computerized OPD & other collections to all the hospitals.
ii) Strengthening the manpower for collection, accounting and auditing.
iii) Strengthening the monitoring activities by vigorously following Health Management Information System (HMIS).
iv) Strengthening of Information, Education and Communication (IEC) activities to increase the access of the public in the hospitals.

The State Govt. has allowed the PHSC to retain the user charges collected from the patients at the point of collection and use the same for non-salary non-recurring cost purposes to bring about greater improvement in the working of the hospitals. Further, the Corporation has

[8] No. 20/7/89-4HBV/12402, dated 14.5.91

issued detailed guidelines to all the Civil Surgeons, Dy. Medical Commissioners for use of the retained revenue.[9]

In order to ensure effective utilization of the revenue, financial powers have been delegated to concerned officers. The SMO in-charge is entitled to accord necessary single sanction up to Rs. 10,000 (in model and big hospitals) and Rs. 5,000 in other hospitals while the DMC in-charge is entitled to accord necessary single sanction up to Rs. 25,000 (in model and big hospitals) and Rs. 10,000 in other hospitals and the Civil Surgeon in-charge is entitled to accord necessary single sanction up to Rs. 10,000/-. Additionally, the hospital in-charge would have the authority to make decisions pertaining to maintenance and repair of hospital equipment as well as minor purchases such a mattresses, dressing material and other items, without seeking approval from the headquarters. During the financial year 2003-04, user charges amounting to Rs. 1254 lakh (unaudited) were collected as against Rs. 1070 lakh collected during the year 2002-03.

The delegation of authority and the responsibility to hospital I/Cs has enabled them to take management decisions on their own level and ensure supply of essential drugs and consumables. The hospitals have also kept electricians and plumbers on a retainer basis, thereby enabling better maintenance of the building. The collection and retention of the user charges at the facility level has been a big step in providing functional autonomy to the hospitals.

B. Health Insurance

The Department of Health through PHSC is carrying out a feasibility study for developing medical insurance scheme for government employees, pensioners and people below poverty line to whom free medical services are provided by the state.

The study estimates that the number of eligible persons would include about 4 lakh employees belonging to the GoP, 1.25 lakh pensioners and 3.88 lakh families living below poverty line. By taking an average family size of 5 and 1 dependent for every pensioner, the total number of beneficiaries would equal about Rs. 41.90 lakh. The benefits which would be extended include provision of free outdoor and indoor medical services to the people possessing yellow cards; payment of Rs. 250 per month to every employee & pensioners as a Fixed Medical Allowance; reimbursement of indoor treatment to government employees & pensioners subject to some restriction; and reimbursement of money actual spent on chronic illness to all government employees & pensioners.

This system seeks to address the unmet needs of all stakeholders and lays emphasis on developing a cashless, transparent, financially viable and easily administrable mechanism. The logistics of administering the scheme could probably be outsourced to Third Party Administrators (TPAs) who specialize in managing these kind of activities in an efficient and cost-effective manner. This study seeks to develop mechanisms which address these specifications. The World Bank had agreed to fund this study and the TOR for the same had been approved. As

[9] It is stipulated that of the amount collected, 45% be spent on drugs and consumables including I.V. fluids, X-ray films, purchase of laboratory reagents, bandages; 25% be spent on improving the facilities available to patients such as washing or replacing of bed sheets, purchase of mattresses, repair/painting of hospital furniture, laboratory equipment, cleaning of wards, laboratory, toilets amongst others. Another 15% be spent on maintenance of the building including emergency repairs and the remaining 15% be used for maintenance of medical or non-medical equipment.

of now, the consultants who will be conducting the study have been finalized. The PHSC is exploring the possibilities for getting the study funded by the UNDP or from the State Government as the World Bank funding has closed on 30.3. 2004.

(IV) Re-organization and re-structuring of existing system

A. Development of a Disease Surveillance System

The Disease Surveillance system makes use of Geographical Information System (GIS) and the State has selected 21 communicable and 12 non-communicable diseases for active surveillance. In addition to the diseases covered under the national programmes, 7 out of the 21 communicable diseases which account for 95% of OPD and IPD cases have also been identified as priority. Surveillance Committees have been formed at district and village level and includes stake holders beyond the formal public health system. For example, District Surveillance Committee includes representatives from Indian Medical Association, Municipal Corporation, leading private practitioners and principals of schools and colleges. Data collected from each of the hospitals is consolidated at the district level, which is then analyzed at the State headquarter with the help of the GIS. Attempts are now being made to link the surveillance system under the project with the larger public health system managed by Directorate of Health Services.

B. Development of Performance and Quality Indicators for Hospitals

The Hospital Management Information System (HMIS) has been designed with a view to provide core quality indicators for every hospital. Using selected parameters related to inputs (e.g. number of beds, vital drugs, etc.), processes (e.g. number of patients attended in OPD, number of deliveries conducted, number of blood units collected, segregation of waste, number of radiological tests done etc.) and output (e.g. proportion of patients referred to higher institutions), the system assigns a mark against each indicators vis-à-vis set benchmarks. For instance, a 50-bedded hospital is assigned 10 marks if the number of OPD cases are 3000 or more.

Based on the performance, every hospital is placed under one of the six categories, namely A+ (when the total score is 90% or more against maximum possible), A (81-90%), B+(71-80%), B(61-70%), C+(51-60%) and C (40-50%). The results for the 14 hospitals covered show that 2 hospitals obtained the highest grading of A+; 2 received A grade; 5 received B+ grade; 4 received B grade while one hospital was placed in grade C. Besides the core quality indicators, detailed performance reports are also being generated for every hospital, which includes indicators like bed occupancy rate (BOR), turn over rate (TOR), average length of stay (AVLS), out-patient / in-patient ratio (OP/IP), number of out-patients, admissions, surgeries, deliveries, lab tests, X-rays and ultrasound

C. Improvement of laboratories

External Quality Assurance Programme has been introduced by tying up the Christain Medical College (CMC) Vellore to check the quality of clinical laboratories. Presently, some of the laboratories of the PHSC hospitals are among the first ten in the India.

In 5 districts (Jalandhar, Hoshiarpur, Ropar, Sangrur and Ludhiana), all peripheral clinical laboratories have been brought under the control of the district hospital clinical laboratory to monitor their functioning as well as to provide them with technical assistance. Under the scheme, a team comprising a pathologist and a senior lab technician will undertake frequent inspections of the peripheral laboratories.

D. Revamping of primary health care services

In light of strengthening of clinical services at the secondary level, the state Government seeks to fill the gaps in the health care system at primary health care as well as strengthen the linkages between primary and secondary system and thereby ensure availability of clinical services to a maximum number of people.

Recently, Punjab has completed the implementation of US$ 100 million World Bank supported "Second State Health Systems Development Project". Under this project, 154 secondary level health institutions have been revamped. The World Bank in its final review has rated the achievement of development objectives under this project as highly satisfactory. The World Bank has further emphasized the State to foster integration between primary and secondary levels of care in the delivery of health services in Punjab. With this idea the World Bank had also agreed in principle to fund a study with regard to restructuring, revamping, and refurnishing the primary health care delivery systems in the State. A study was undertaken to identify various critical gaps in the primary level health care delivery systems. Based on the study, the State government prepared a draft project proposal seeking bilateral aid to the tune of Rs. 614.11 crore.

The proposal has been forwarded to the Ministry of Health, to be further taken up with the Ministry of Finance, Department of Economic Affairs, New Delhi and thereafter forwarded to the World Bank authorities for their appraisal and support. The proposal also acknowledges the dire need to improve IMR, MMR rates, reduce anaemia as well as the number of under-weight children less than four years of age. The proposal lays emphasis on improving vital health indicators, addressing issues like declining sex ratio, burden of communicable & non communicable diseases, higher prevalence of TB. The Govt. of India, Planning Commission, as well as the State government have made provisions in the 10th Plan and in the Annual Plan FY 04-05 to support this project.

E. Ensuring Health care delivery through better mobility

The present medical set up in the State of Punjab has 117 CHCs, out of which 70 are located in rural areas and 47 in urban areas. Each CHC covers a population of 0.8 lakh - 1.20 lakh. Under each CHC, there is an average of 4 primary health centers, each covering a

population of 30,000 and 6 Sub Centers each covering a population of 5000. With a view to ensuring more effective utilization of the infrastructure existing in the hospitals of the State of Punjab, it is proposed to provide linkages between the primary and secondary sector institutions. The proposal consists of introducing fully equipped mobile clinics linking PHCs/SHCs with the CHCs, thereby ensuring better services to a larger section of the population, particularly in the rural areas. The proposal will also cover Homeopathy and Ayurvedic institutions by integrating their functioning wherever required.

F. Maintenance of assets

Quality management implies no wastage as well as investment of some funds in the maintenance of assets created. With increasing emphasis on maintenance of assets, to ensure their longevity, the PHSC has prepared a comprehensive scheme for maintenance of assets by creating a special wing within the corporation, which will take care of extensions, renovations and maintenance of all health infrastructure in the State namely, under Director Research and Medical Education (DRME), Punjab Health System Corporation (PHSC), Department of Health & Family Welfare (DOHFW), Employee State Insurance Corporation (ESIC) and Directorate of Ayurveda and Homeopathy.

G. Medical Audit

Record keeping has been found to be a major deficiency in the hospitals and a pilot was taken up to develop a proper medical records system. Standard Operating Procedures were developed for admission and discharge of patients and training imparted to the hospital staff. However, an evaluation undertaken at selected hospitals (being developed as model hospitals) indicated that while there was a general improvement, progress notes were not being written in most cases and the discharge notes were not sufficient.

H. Development of a Referral System

The referral system designed under the project allows queue jumping and exemption from registration / admission / bed charges. For instance, at the medical colleges, a patient holding a referral card will report to the 'senior citizen' counter of the OPD; an OPD ticket will be issued and stamped 'referred-in'; and the consulting doctor may give preference to a patient holding an OPD ticket with the 'referred-in' stamp. The sub-centres have been provided with the referral cards and the data on the referrals has started to flow.

I. Waste Management

In the area of waste management, considerable developmental work has been completed. This includes supply of equipment, training of medical and paramedical staff and finalisation of a comprehensive health care waste management manual. However, attitudinal change and motivation levels appear to be still low. It is now proposed to adopt an incremental approach (starting from the district hospitals) and allow every hospital to develop its own written policy guideline. It is also proposed that the hospitals in large cities tie up with central facilities under the municipal authority.

Annexure

Profile of Punjab

Population	
Population (millions) (2001)[1]	24,289,296
Estimated Urban Population (%) (2001)[2]	33.95
Scheduled Caste population (%) (2001)[1]	28.9
Scheduled Tribes population (%) (2001)[1]	0
Vital Statistics	
Life Expectancy at birth (Male) (in years) (1996-2001)[3]	68.39
Life Expectancy at birth (Female) (in years) (1996-2001)[3]	71.40
Total Fertility Rate (per woman) (1999)[3]	2.5
Sex Ratio (females per 1000 males) (2001)[1]	874
Birth Rate (per 1000 population) (2002)[4]	20.8
Death Rate (per 1000 population) (2002)[4]	7.1
Socio-Economic Profile	
Literacy Rate (total) (%)(2001)[1]	69.95
Net State Domestic Product (2000-01)(P) (Rs. in millions) (at current prices)[5]	586130
Main workers to total population (%) (2001)[3]	32.23
Population Below Poverty Line (%) (1999-2000)[6]	6.2
Water, Environment & Sanitation	
Households having access to safe drinking water (%)(1991)[7]	92.74
Households with no toilet / latrine facility (%) (1998-99)[8]	48.6
Health Status	
Infant Mortality Rate (per 1000 live births) (2002)[3]	51
Deliveries assisted by a health professional (%) (1998-99)[8]	62.6
Health Infrastructure	
Number of Medical College Hospitals (MCH)	5
Number of District Headquarter Hospital (DHH)	18
Number of Total Allopathic Hospitals (As on 1.1. 2001)[9]	219
Number of Community Health Centres (CHC) (As of 31.03.2001)[10]	117
Number of Primary Health Centres (PHC) (as of 31.03.2001)[10]	484
Number of sub-centres (SC) (As of 31.03.2001)[10]	2852
Health Financing	
Total Health Expenditure as % of total expenditure (Rs. in millions)[11]	3.81
Public Expenditure on health (Total) (Rs. in millions) (2003-04)[12]	7117
Per capita public health expenditure (Rs. in millions) (2003-04)[11]	292

[1]Census of India, 2001
[2]Urban Statistics Handbook, 2000
[3]SRS, RGI
[4]SRS, RGI, 2002
[5]Directorate of Economics & Statistics (As of March 2004)
[6]Planning Commission
[7]Census of India, 1991
[8]NFHS-2
[9]Health Information of India 2002
[10]Health Information of India 2000 & 2001
[11]Response from Govt.of Punjab
[12]State Budget Document 2003-04

In Punjab, village panchayats were first set up formally after the passage of the Punjab Village Panchayat Act in 1912 which was later replaced by the Punjab Village Panchayat Act, 1921 and then by the Village Panchayats Act, 1939. After independence, the Indian Constitution placed the Panchayati Raj System under the Directive Principles of State Policy. In Punjab, both the institutions, namely Village Panchayats and District Board, were sought to be democratized and re-empowered through a new Act namely, the Punjab Gram Panchayat Act, 1952. The Panchayati Raj system was reorganized in 1961 and new additions were made for the adoption of the three-tier pattern in the Punjab Panchayat Act, with the introduction of the Panchayat Samitis and Zilla Parishads Act, 1961. This new three-tier system became operative from 1962-63 and functioned as representative bodies upto 1970 and again from 1975 to 1978. (In the intervening period from 1970-1975, these had been dissolved). Thereafter, these two tiers remained with government officials till 1994. Elections to the Gram Panchayats (first tier) were held regularly since independence, with the exception of 1988 due to the turbulent situation in the state. With the passing of the 73rd Constitutional Amendment Act, 1992, the state government enacted a new panchayat Act,namely, the Punjab Panchayati Raj Act, 1994, which came into force in place of the Gram Panchayat Act, 1952, on 21 April 1994. New rules were framed under the provisions of this new Act and the first elections to 138 Panchayat Samitis and 14 Zilla Parishads were held in 1994, and 2,441 Samiti members and 274 Zilla Parishad members were elected. The village Panchayat elections were held in June 1998. Recently, elections to Panchayat Samitis and Zilla Parishads (which were due in 1999) were held in June 2002, for which 2,485 members of Samitis and 281 members of Zilla Parishads were elected by the members of the Gram Sabhas for 140 Samitis and 17 Zilla Parishads respectively.

Rajasthan

RAJASTHAN

Rajasthan evokes multihued images of a land of gallant rulers and bedecked camels dotting the desert landscape. In the last fifty years, it has emerged as a major tourist destination in India, both for the domestic and foreign tourists. Rajasthan has a total geographical area of 3,42,239 sq. km. The state was formed in March 1949, by a merger of 19 principalities and 2 chief ships, with Ajmer-Merwara being added in 1956, as recommended by the States' Reorganization Commission. Admin-istratively, it is divided into 32 districts, which are further sub-divided into 241 tehsils and 237 development blocks. The State is characterized by a dispersed pattern of settlement, with diverse physiography ranging from desert and semi-arid regions of Western Rajasthan to the greener belt east of the Aravallis, and the hilly tribal tracts in the Southeast. More than 60 percent of the State's total area is desert, with sparsely distributed population. Agriculture continues to be dependent on rainfall, the failure of which causes severe drought and scarcity conditions. The decadal growth of population is high in Rajasthan, while the literacy level, especially for girls, is among the lowest in the country. At the same time, Rajasthan has witnessed several important initiatives involving voluntary groups, issue-based citizens' action, and democratic decentralisation. There have been efforts by citizens to organise themselves to fight perceived injustice and specific causes. Some notable examples of public action include the movement for right to information.

Organization of Health Services and Programmes

During the last few decades, the medical and health infrastructure has expanded considerably in Rajasthan, particularly in the rural areas. As in other states, Rajasthan too is involved in implementation of various national health programmes. The UNFPA supported IPD[1] project is also under implementation while the Secondary Health System Project supported by the World Bank is also underway. Some of the challenges facing the health sector include provision of healthcare for infants and children; reproductive health and antenatal and postnatal care of the mother; diseases associated with poverty; and poor sanitation. The burden of disease imposed upon women by patriarchal culture the stark regional and social disparities, increasing signs of discrimination against women, and the poor condition of health services needs to be addressed on a priority basis.[2]

In an attempt to improve access to health care, the State has been investing over 50% of the plan funds for primary health care for the last decade. At the same time, in order to ensure sufficient funds for development of secondary and tertiary levels of care, the State Government has attempted certain reforms and innovations.[3]

Reforms initiatives in Rajasthan include:

(I) Public Private Partnership

A. Participation of the private sector in health[i]

With a view to participation of the private sector in health, the Government of Rajasthan has initiated a series of policy measures. These include formulation of a policy

[1] The Integrated Population and Development (IPD) project is being implemented in seven districts of Rajasthan through UNFPA assistance since February, 1999.

[2] Govt. of Rajasthan (2002), "Rajasthan Human Development Report 2002", Government of Rajasthan.

[3] Govt. of Rajasthan (2003), Power-point presentation on 'Rajasthan Health System Reforms: A Perspective' at the workshop on India's Health System: Role of Health Sector, September 4-5, 2003, New Delhi, organized by GOI in collaboration with the WHO.

on private sector participation for installation of sophisticated medical technology in public sector hospitals, policy of medical colleges / dental colleges in private sector, formation of guidelines for setting up nursing institutions in the private sector and rules regarding acceptance of donation and charities from private individuals or public bodies for medical purposes.

(i) Policy on private sector participation for installation of sophisticated medical technology in public sector hospitals[4]

With a view to equip the government hospitals with latest diagnostic and treatment machines/equipment, the GoR decided to involve the private sector to install these diagnostic/treatment machines/equipment in hospitals. The Medicare Relief Society has the authority to decide the number and type of diagnostic/treatment machines required for efficient functioning of the hospital. The broad criteria for deciding the number and type of machines is based on patient load and capacity of the machines already installed in the hospital. The machines/ equipment would be divided in two categories: (a) Investigative/diagnostic Machines[ii] and Equipment and (b) Treatment machines[iii] (e.g. Lithotripsy). While fixing rates for procedures, the element of cross subsidization for exempted categories like BPL families/ widows/ destitute and others is also kept in view.

Following the implementation of this policy, no new diagnostic machines/equipment and sophisticated treatment machines would be purchased either from Government budget or from RMRS funds. Thereafter, only in cases where private investment might not be feasible, cases for prior permission of the Government would be moved for such purchases. Existing machines would continue to be operated by the hospitals till they became obsolete or beyond economical repair/ replacement. If a machine/equipment is under utilized, the Government would consider transferring it to the private sector, to avoid uneconomical operation and unnecessary burden on state exchequer. For ensuring quality of tests, quality protocols would be developed and circulated for implementation. This policy is expected to benefit the patients as availability of ensured clientele in public hospitals would bring down the rates of various tests/procedures considerably as compared to the market rates. Once the machines are installed, the doctors would not be allowed to refer patients to other private centers for tests in the areas for which facilities are available in hospitals.

(ii) Policy for medical colleges / dental colleges in private sector[5]

To involve the private sector in augmenting the availability of doctors and medical facilities in the state, a policy for private sector participation in Medical and Dental education was announced. This policy seeks to attract investors to set up Medical and Dental Colleges in the private sector in the State. As per the Cabinet decision on the subject[6] and recommendations of the Empowered Committee for Establishment of Medical and Dental Colleges in private sector, the essentiality certificate cum NOC for establishment of Medical College/Dental College in private sector in the State will be issued by the Sub Committee of the administrative department subject to certain conditions.

[4] Department of Medical, Health & Family Welfare Services, GoR (2000), Policy on private sector participation for installation of sophisticated medical technology in public sector hospitals, Govt. of Rajasthan & GO No. F.15 (5)MPH/Gr.-2/99.

[5] Department of Medical, Health & Family Welfare Services, GoR (2000), Policy for medical colleges / dental colleges in private sector, Govt. of Rajasthan

[6] No.67/97 dated 7.8.1997

These conditions include undertaking by the applicant organization to follow norms and directives of the MCI/ DCI and the Supreme Court regarding fee and other aspects of admissions; to establish College & Hospital in a given time frame; agreement to abide by the selection/admission criteria laid down by State Govt. MCI and DCI and availability of sufficient funds for development and guarantees. Thereafter, only eligible applications are forwarded to MCI/ DCI/MOHFW. It is further stipulated that the applicant organization needs to have sufficient land for establishment; development and expansion of College and Hospital, under its ownership.

The final decision is based on availability of land with the organization, availability of hospital having minimum 300 beds for Medical College / 100 beds for Dental College with scope for expansion, involvement of associates from the field of Medical Sciences, Administration/ Management and Financial Management amongst other criteria.

(iii) Guidelines for setting up nursing colleges[7]

With the purpose of augmenting availability of trained para medical/ nursing personnel in the State, guidelines have been issued for setting nursing colleges in the private sector. It is stipulated these schools follow the curriculum prescribed by the Indian Nursing Council/ Rajasthan Nursing Council. The school is required to fulfill prescribed standards/requirements set by Indian Nursing Council/Rajasthan Nursing Council with regard to teaching staff; physical facilities; clinical facilities including hospital and field practice area; hospital beds etc; admission criteria and process. Further, they must be registered under Societies Registration Act 1860, Trust Act 1882, Wakf Act 1954, or under similar legal provisions applicable in the State.

Procedurally, the recommendation for granting permission to establish nursing training institution is forwarded to Indian Nursing Council. Priority is given to organizations having their own hospital with 150 beds. Those not having their own hospital are required to submit an agreement letter from the Superintendent of the hospital, that such facilities will be made available for a minimum, period of three years. It is also required that such hospitals are located within a radius of 10 km from the training school. Attachment with any government hospital is not permitted. Stipulations are made about the proportion of male and female students to be admitted, proportion of NRI candidates who can be admitted, and reservation rules. A committee comprising of Secretary, Medical & Health & FW, Director, Medical & Health Services and others is the final decision making authority.

(iv) Rules for acceptance of donations and charities[8]

The Government of Rajasthan has formulated rules, called the Rajasthan Medical Institution (Contribution) Rules, 1980 for acceptance of donations and charities from private individuals or public bodies for medical purposes. As per provisions of these rules, any contribution, subject to its acceptance by the Government would consist of cash or be in kind for equipment, drugs, food materials or any property moveable or immovable, legally transferable for the purpose of Medical

[7] Department Of Medical, Health & Family Welfare Services, GoR (2000), "Guidelines for setting up of nursing institutions in private sector", Govt. of Rajasthan

[8] Department of Medical, Health & Family Welfare Services, GoR (2000), "Rules regarding acceptance of Donations & Charities from Private Individuals or Public Bodies for Medical purposes", Govt. of Rajasthan

Institutions & Services. Every contribution made under these rules can only be utilized for the specific object or purpose for which it has been made. Any person/s or public body desirous of making a contribution is required to apply in writing to the Government, offering the same and also stating the purpose for which the offer may be utilized. In cases where the government accepts a contribution for the purpose of construction works, it may if required, allot land free of charge. It is stipulated that in such cases, the land shall remain the property of the government, its construction and furnishing shall be in accordance with the plan prepared or concurred by the State Public Works Department and that the building so constructed shall vest with the State Medical & Public Health Department.

The amount of contribution which can be accepted by the authority or authorities at various levels has been laid down. For instance, the Director of Medical & Health Services can accept a donation upto Rs. 10 lakhs. These donations are meant for betterment of the existing facilities and should not impose any additional financial liability on the State. Further, any contribution received under these rules, is required to be notified in the Rajasthan Gazette. A gift deed appropriately modified and approved by the competent authority, is required to be executed for all items of donations accepted under these rules.

(v) Policy to encourage private investment in hospitals, diagnostic centres & nursing homes

In order to encourage the private investment in hospitals, diagnostic centres and nursing homes, Medical and Health Department of Government of Rajasthan (GoR) developed a detailed policy in 1996.[iv]

Since then, the GoR has developed a policy for attracting private investors including Non Resident Indians to set up their projects in the health sector. This policy encourages the establishment of hospitals (having atleast 50 beds along with OPD facilities), diagnostic centres, charitable medical institutions and nursing homes (having atleast 10 beds along with OPD facilities). As an incentive, land is allotted for setting up various categories of medical institutions in the private sector, at 25 percent of the market price of agricultural land in rural area for upto 10,000 sq. meters and at 50 percent of market price for more than 10,000 sq. meters. In urban areas, the land is sold at the reserve price for residential purposes.

The policy accords concessions to poor patients. Medical institutions that have been allotted land on concessional rates are required to provide at least 10 percent of beds free to BPL card holders. They would be charged only 25% of the cost of medicines, diagnostic tests and other expenditure. Furthermore, such institutions are required to provide OPD facility for one hour daily, twice a day for BPL card holders, economically weaker sections and to poor patients. They are also required to maintain separate records of poor patients given free service.

In case, the land allotted is not utilized for setting up various categories of institutions within a period of three years from the date of allotment, the same would revert back to Government and any structure erected

on it, would become the property of the State Government.

A State level Empowered Committee under the chairmanship of Chief Secretary set up under a single window system would consider the proposals referred to the Government for providing facilities and incentives under the policy.

B. Outsourcing of services

In the State of Rajasthan, contracting out has been undertaken for the cleaning services in hospitals, management of the cycle stand as well as the canteen. Details of the same are being ascertained.

(II) Decentralization

A. Initiatives in Decentralization

The Government of Rajasthan has embarked on a programme of strengthening panchayats and granting them a greater role in governance and public affairs. The linkage between decentralisation strategies and health care has become an important thrust area. Following the 73rd and 74th Constitutional Amendments, the Rajasthan Panchayati Raj (Modification of provision in their application to the Scheduled Areas) Act 1999 has been enacted in order to provide wide ranging powers to the village committees in the predominantly tribal areas. By way of legislation, all sarpanchas have been made members of respective Panchayat Samitis and similarly all pradhans have been made members of Zila Parishads. Furthermore, 29 subjects have been identified for transfer to panchayats under section 243 G of the 11th schedule of the Constitution. Out of these, in 16 subjects viz. Medical and Health, Family Welfare, Ayurveda, Renewable Energy, Forests, Animal Husbandry, Fisheries, Rural Development, Agriculture, Food & Civil Supplies, Social Welfare, ICDS, Irrigation, PHED, Primary Education & Literacy, the local level institutions have been transferred to PRIs in Rajasthan.

The other developments include decentralization of planning to the district level through District Planning Committees which is headed by Zila Pramukh. The planning and execution of local level schemes is being increasingly done through a three-tier Panchayati Raj structure. The Chief Planning Officers posted in the districts serve as Member-Secretaries of these committees with the overall function being overseen by the Panchayati Raj Department at State Level. Procedures have been evolved in order to ensure effective social audit of all developmental programmes through the meetings of Gram and Ward Sabhas.

However, there are some inherent problems in the interface between panchayats and the health system. These relate to the disjunction in jurisdiction between panchayats and the tiers of the health system. Further, the technical character of delivery of curative health services does not confirm to the current cultural and capacity mode of panchayats. Therefore, investment in building capacity of local bodies for better health planning and management is seen as essential.

(i) District Reproductive & Child Health (RCH) Society & Decentralized Programme Management

The Government of Rajasthan constituted District Health Societies (DHS) in all districts[9] thereby merging four

[9] GO dated 15th July 1999

societies – Malaria, Tuberculosis, Leprosy and Blindness into a District Health Society. Through this initiative, it sought to ensure extensive decentralization of powers and responsibilities to the district level. Guidelines were laid down pertaining to registration, membership criteria, roles and responsibilities of members, meetings, etc. It was envisaged that the DHS would be responsible for approval of annual plans and budgets. The Health and Family Welfare Department officials were empowered to implement the plans, once approved without any need for subsequent approvals on files.[10]

The District RCH societies were registered in 1999 to facilitate implementation of World Bank funded RCH project. Thereafter, in the UNFPA supported seven IPD[11] districts, these societies were extended to include IPD project objectives. A major shift in the implementation strategy of the IPD Project is the decentralization of programme planning, implementation and evaluation through District RCH Society (DRCHS). The DRCHS has the authority and accountability for project implementation. It has full powers to make financial and administrative decisions subject to the overall guidelines and directions issued by the GoR.

In the year 1999-2000, the UNFPA-IPD project[12] implementation started through the extended District RCH societies. As a first step, the members of the Societies were oriented about the objective and functioning of society. Thereafter, the financial and budgetary rules for the functioning of societies were developed and shared with district societies; the details of recruitment process for the staff of District Project Management Cell (PMC) were developed by State Project Management Unit (PMU) in consultation with office bearer of district societies. The staff of newly established District Project Management Cell (PMC) and District RCH officers were oriented about the functioning of District society mechanism in a state level workshop and efforts were made to provide support in terms of technical inputs and guidelines required to enhance capacity for decentralised management.

In the initial stage, it was felt that decentralisation of project management at district level created several layers of bureaucracy resulting into lengthy procedures of decision making. One of the most difficult tasks faced by state PMU was to bring about changes in the functioning style of district officers. In the month of August 1999, a meeting of all Chief Medical and Health officers was organized wherein the Chief Medical & Health Officers expressed that the working of societies had been centralised by Collectors resulting into delay in decision making. The secretary (FW) issued a circular to clarify the role of chairman and other issues related to functioning of district societies. This helped to an extent to systematize functioning of district societies. In the second year of project implementation, functioning of district societies were analyzed at the state level. It was observed that though the society mechanism brought about structural, functional and operational changes into functioning of government system at district level, the results were not reaching upto the expected levels. Some of the issues identified included, the manner in which the meetings were organized, systems for programme

[10] Department Letter dated, 12th August 1999

[11] The project aims to improve access and quality of reproductive health services, contribute to promotion of gender equity and equality, introduce missing RH services, address the needs of sub-population, enhance availability and utilization of emergency obstetric care and enhance management capabilities at state and district level through promotion of decentralized programme planning and management.

[12] Kumar Abhay & Jain M.L (2003), "Decentralized Program Management: An IPD Experience", IPD Project Review Workshop, jointly organized by GOR and UNFPA, 15 Feb 2003

monitoring and financial control. Hence, an attempt was made to streamline functioning of district societies, so that expected project objectives could be achieved in the project period.

The District Society has a Governing Board (GB) chaired by District Collector. The Chief Medical & Health Officer / District RCH Officer (RCHO) is the Member Secretary of the GB[v]. The Executive Committee (EC) of the DRCHS is chaired by the CM&HO and has to meet every month to develop operational plans, review progress and ensure project implementation on the laid down procedures and on the guidelines issued by GoR[vi]. The RCHO is the member Secretary of the Executive Committee.

In terms of programme implementation, at the National level, the Department of Family Welfare under the Ministry of Health and Family Welfare, GOI is executing the project. At the state level, this is managed and implemented by Department of Health and Family Welfare. The other project partners include, Department of Women, Child Development. Education, Panchyati Raj, the Women's Resource Centre (WRC) and non-governmental agencies involved in the implementation of IPD activities at the state level. The Dy. Secretary (Medical Group V) is the Project Director of IPD project while at the district level, the programme is implemented through the DRCHS under the Chairpersonship of the District Collector. It provides for active participation of elected public representatives and NGOs in the planning and implementation of the activities, close coordination among the on-going health and FW projects and partner departments.

The challenges faced in establishing a society mechanism for decentralized program management brings out the important role played by individuals as well as the adverse impact of the frequent turnover of officials on systematization of the society. It is apparent that time needs to be invested in ensuring that district officers initiate appropriate decision making processes especially since, at times the delegation of authority to district society is perceived as a redistribution of the existing decision making authority and resisted by those who fear the potential loss of power. At such a juncture, State government needs to create an environment so that the people particularly at the state level accept change. This clearly brings out the necessity to develop clear understanding among the key officers about their role and responsibilities to make decentralization process functional. Furthermore, the involvement and commitment of members of society from other government department, NGOs and PRI representatives is essential for ensuring the success of this effort.

(III) Reforms related to Human Resources

A. Appointments on contractual basis

With a view to fill in the large number of posts of Medical Doctors lying vacant in districts, and thereby having an impact on the care and treatment of patients, the State government decided to hire the services of Medical Officers (MBBS degree holders), either by way of hiring retired doctors or appointing doctors on an ad-hoc basis.[13] The state government decided to hire services of retired doctors in 10 districts. A committee comprising of the concerned District Collector and Chief Medical

[13] GO No. F (33) MPH/Gr.II/94 dated 26.10.1994

& Health Officer appoints these Medical Officers, subject to certain terms and conditions. The terms and conditions stipulated that these contractual appointments would be made for a period of one year, and would be subject to extension, if required; the doctor should not have crossed 65 years of age and should be in good physical health. The remuneration is fixed at Rs. 150 per day. These appointments were made as against sanctioned posts only and the Chief Medical Officer is responsible for issuing the appointment orders, based on the recommendations of the above mentioned committee.

In case of ad-hoc appointments of doctors, the Chief Medical Officer is authorized to appoint doctors against sanctioned vacant posts, based on recommendations of the committee, which comprises of the District Collector, Joint / Deputy Director posted at respective divisional headquarter, the concerned Treasury Officer and the CMO himself/herself. The presence of the District Collector is essential at the time of the committee arriving at any decision pertaining to these appointments. These ad-hoc appointments are made as per the usual terms and conditions. Similarly, contractual appointments are being given to Auxiliary Nurse Midwives (ANMs), Laboratory technicians, Staff nurses and medical officers at the district level.

Since the implementation of this scheme, certain modifications have been affected. The details of the same are being ascertained.

B. Initiation of three month anaesthesia training

In order to address the shortfall of anaesthetists and bring about rational allocation of resources, a three month training in anaesthesia has been initiated. This initiative aims to address the design problem, wherein at the CHC level, provisions were made for appointment of surgeons. However, no stipulations were made to ensure that supportive services of anaesthetists too are available to the surgeons. Hence, a short term training course of three months was started wherein the Medical Officers were trained as anaesthetists. As a response to this, cases were registered in the High Court against these doctors, thereby leading to lack of interest in this initiative. In order to address these problems, a blueprint for ensuring availability of anaesthetists at all CHCs was developed. The interventions planned, included, identification of anaesthetists who have already undergone the three month training and their re-deployment; creating an inventory of those already trained and working as anaesthetist and seeking certification, launching a five and half month training programme supported by the Govt. of India in anaesthesia; increasing the number of post-graduate and diploma seats in anaesthesia, re-designating MOs at CHC as MO-Anaesthesia and retaining the option to train surgeons and gynaecologists in local anaesthesia.

(IV) Changes in Financing Methods

A. Formation of Medical Relief Society[14-15-16]

[14] Mangal D.K, (2004) Institutionalization of user charges in government hospitals in Rajasthan, Indian Journal of Health Management, Sage Publications, 6 (1), pp. 1-22.

[15] Mangal D. K, (2004), Power-point presentation on "User fees in Rajasthan" at workshop, 'Strategies for Health Financing in India' January 14, 2004, New Delhi

[16] Lubhaya Ram (2000) Health Financing: Cost Recovery Policies in Rajasthan in 'Financing Reproductive & Child Health Care in Rajasthan', IIHMR – The Policy Project, pp- 85-91

The first attempts at cost recovery and cost sharing in the early 1980s, took the form of 'pay clinics' and 'auto finance schemes'. In the pay clinics, specialists were permitted to offer consultation services in hospitals on specified days and time, usually immediately before or after the hospitals hours, for a fixed fee. The patients were charged consultation fees by the hospitals, a part of which was distributed to the specialist doctors and the rest was deposited in the government exchequer. An Auto Finance Scheme (AFS) was introduced in 1982, wherein nominal charges were introduced for diagnostic tests, mainly for X-rays. The revenue was to be deposited in the exchequer and the institution was then allotted additional budget for consumables based on its earnings. These schemes became dysfunctional over a period of time and proved to be unsuccessful. The probable reasons for that include, lack of interest on part of the participating specialist doctors and institutions, lack of any incentives to generate revenue, and the fact that the revenue generated was deposited in the State Treasury.

In the face of problems like dwindling public resources in real terms, shortage of diagnostic facilities and laboratory equipment, a general deterioration in physical infrastructure, a need was felt to mobilize resources from the community. Hence, the Medical and Health Department decided to create an autonomous society with a view to introduce collection of user charges vide a government order[17] to create Medicare Relief Society (MRS) in medical college hospitals and all district hospitals under section 20 of the Rajasthan Societies Act, 1958. A draft constitution and rules were enclosed for reference and adaptation. The societies are registered at hospital level, district level and sub district level and have now been expanded up-to community health centre (CHC) level. In all 304 Medical relief Societies are currently functional in Rajasthan.

Numerous guidelines and orders were issued to ensure effective functioning of these societies. In 1996, the MRS was scaled up to cover all hospitals having upto 100 beds. By way of an order[18], the control of all equipment, earlier used under the auto finance scheme was transferred to the societies, along with the responsibility for maintenance of the same. Thereafter, purchase of hospital equipment was permitted[19] under the Sahbhagi Nagar Vikas Yojana, wherein if half of the cost of the equipment was obtained through public contribution, the State government contributed the remaining half. Amendments were also made to the Rajasthan Civil Service (Medical Attendance) Rules, 1970 so as to allow reimbursement of the charges paid by the government employees to the MRS for diagnostic tests and investigations. Thereafter, it was decided that the Governing body (GB) of the MRS should include a public representative. Hence, all societies passed a resolution to this effect and MLAs could then be nominated by the government as members in MRS. Another development was the setting up of Life Line Fluid Stores in August 1996 in the SMS Hospital. This was followed by all the societies being advised to start similar outlets in their respective hospitals.[20] Given the positive experience of running MRS, a decision was taken to start such societies at all hospitals having 100 beds and a circular

[17] GO issued on 29thSeptember 1995
[18] GO dated 1 February 1996
[19] Department letter dated 11 April 1996
[20] Departmental letter dated 3 September 1996
[21] Circular dated 17 September 1996
[22] Circular dated 23 January 1998
[23] Dated 27 February 1997

to this effect was issued.[21] Thereafter, MRS was started in all hospitals having less than 100 beds through another circular.[22]

In the interim period, various other orders were passed. These included retaining income from cottage wards / private wards and auditorium[23]; provision of free services to poor, freedom fighters, pensioners, retired army men, accident cases, destitute, senior citizens and free investigations under the various national health programmes.[24] In the same year, guidelines were issues for fixing user charges, regular audit of accounts of the society by a Chartered Account and usage of excess revenue in the same calendar year[25] and exemption of donations received from income tax under section 80G of the IT act.[26] In 1998,[27] guidelines were issued for utilization of revenue generated by the societies. These guidelines stipulated that that up to 50 percent of the revenue could be spent on purchase of new equipment while the other half had to be spent on provision of facilities to patients, cleanliness, maintenance and purchase of items. Detailed guidelines for purchase, maintenance and repair works were also issued.[28]

The MRS is registered separately for each hospital, based on a model constitution and rules provided by the State government. The management structure of MRS consists of an autonomous management committee comprising of 9-11 official and non-official members at State, Regional and District levels. The Executive Committee takes day to day decisions[vii].

Essentially the MRS seeks to compliment and supplement the health facility through generation of additional revenue; retain and use the resources generated in the hospital through decentralized decision-making. The MRS provides low cost diagnostic and treatment services, free medical services to poor and disadvantaged, obtains donations from financial institutions, conserves resources through adopting wards and opening of life line fluid stores, arranges facilities such as the Sulabh complex, maintains buildings, equipment and contracts out services amongst others. It is also authorized to introduce user charges on diagnostics and treatment services. The Society is permitted to retain the revenue generated and to utilize it for improvement of health care services in the respective hospitals. The Society functions outside the purview of the State and the General Financial Rules (GFR) do not apply and it can purchase equipment according to its own requirements. Mainly, the funds in MRS are used for maintenance and renovation of building, maintenance and repair of equipment, purchase of new equipment, improving sanitation and cleanliness, improving other facilities for patients and attendants, computerization of various systems and provision of free medicines for BPL families. The source of funds for the Society includes seed money by State Government and transfer of operational control of diagnostic machines to the societies. As mentioned above, free services are provided to certain sections of the population as stipulated in the order. These include, families living below the poverty line, widows, freedom fighters, destitute, citizens over 70 years and retired government servants.

Cost recovery in Rajasthan averages 10-15% of the hospital budget, although it ranges from 4 to 25% in some institutions. While no systematic costing exercise has been carried out, the rates levied are 50% of the

[24] Order dated 17 October 1997
[25] Letter dated 29 August 1997
[26] Dated 29 September 1997
[27] Order dated 28 January 1998 and 2 June 1998
[28] Dated 15 May 1999

prevailing market rate. Since, the institution of user fees in 1995, the same has been revised thrice. For instance, on an average, the OPD charges are Rs. 2, the inpatient charges being Rs. 5, in-patient referral by private practitioner costs Rs. 10, while the bed charges for the private cabins, cubicles or cottage wards range between Rs. 100-600.

It has been seen that MRS has resulted in improved quality and utilization of services. However, some challenges remain. Some of these include, rational use of surplus funds, ensuring free services to exempted categories, ensuring 25 % of surplus funds are utilized for BPL persons for providing free drugs, ensuring use of funds in the same financial year, developing systems for setting user fee, expanding the scope for levying user fee and ensuring proper systems for perspective planning and accounting.

Regular monitoring of the MRS is undertaken at the level of Director, Health Services and Secretary, Medical & Health Department. The Medical and Health Department provides support to the MRS, monitors the revenue and expenditure on a monthly basis. In August 2000, the state government constituted a state level committee under the chairmanship of the Health Minister to review the working of the MRS.[viii]

At the same time, there continue to remain some policy issues for consideration. Some of the challenges and areas which require more inputs include enhancing management capabilities of the hospital administrators, systems and procedures of procurement, maintenance of equipment and hospital building, contracting and outsourcing, ensuring that the state does not reduce current level of funding, issuing clear guidelines and principles, ensuring adequate representation of public representatives, ensuring that the hospital administrators are oriented and trained well, creating transparent, efficient and accountable systems for collection, retention, and use of excess funds generated, designing intervention in consultation with key stake holders and extending support to the initiative.

B. Establishment of Life Line Fluid Stores[29]

Based on the success achieved in implementing the Medical Relief Society (MRS) in the SMS Hospital Jaipur, another innovative source of finance, the Life Line Fluid Store (LLFS) was established in August 1996 to provide high quality drugs and surgical items to patients at affordable prices. The LLFS is a pharmacy store that functions within the public hospital.

It was seen that I.V fluids and drips, for which there was a big demand, were being sold by the retailers at the printed maximum retail price (MRP) of Rs. 30-35/- (including Local Tax), while the real cost to the wholesaler was in the range of Rs. 6-7. Hence, there was a huge margin, which was passed on to the patient. Given the success of implementing the MRS, it was felt that the MRS could act as an outlet for selling of essential and emergency drugs wherein the drugs would be sold to the patients at a marginal profit and at almost 40 to 50 percent of the market cost. This was the genesis of the LLFS.

As a first step, a dedicated and efficient manager with experience in business was identified, followed by

[29] Chaudhary Ranjit Roy & Gurbani Nirmal Kumar (2004), 'Life Line Fluid and Drug Stores: State Sponsored Cost-Sharing Medical care through autonomous societies' in 'Enhancing Access to Quality Medicines for the Underserved', pp. 10-33, Anamaya Publishers, New Delhi.

identification of space within the hospital for storage and selling of the drugs. An arrangement was worked out, wherein products of interested manufacturers were kept on a consignment basis. Based on the sales, payments were made, after a period of 15 days. A committee of doctors was authorized to select the pharmaceutical products that were to be sold and to fix their sale prices. To prevent the monopoly of any one manufacturer, to safeguard against stock out situations and to ensure uninterrupted and regular availability of products, the price of the lowest bidder of repute was fixed as the standard price of the drug. The quality aspect was assured by selecting only reputed manufacturers approved by the committee of doctors. The suppliers in turn were informed that the LLFS was under no obligation to sell their products and in case of any doubt about the quality, the stock would be returned. Hence, selection decisions are based on information regarding the quality of the products, the market price, the price offered by the supplier and demand, without a tender process by taking a 'lowest price certificate' from the supplier. Branded products of reputed companies are also approved. The benefits of sales from the promotional schemes offered by the manufacturer/ supplier in turn are passed on to the consumers.

The contract for each LLFS is awarded by the MRS to a pharmacist as a contractor for a period of 1-2 years by inviting applications. Guidelines for selection of contractor have been issued.[30] The contractor is provided a fixed salary plus 1% commission on the sale and has to manage the supporting staff from the receipts. The contractor manages the sale, procurement of approved items and maintenance of necessary stock and sale accounts. The suppliers maintain the supplies at their stores, through a 'challan' (a credit note issued by the seller), and receive payment on sale. A separate account is maintained for the LLFS, which is incorporated into the MRS account at the close of the financial year.

As a response to the establishment of the LLFS at SMS hospital, the Chemists and Druggists Association (CDA) started lobbying against it. A resolution was passed, that no supplier would supply drugs to LLFS on a consignment basis. However, this decision was defied by the suppliers, who continued to provide drugs to the LLFS. Presently, I.V. fluids, surgical items and injectable antibiotics are also sold through the LLFS. Following the success of LLFS at the SMS hospital, all the MRS were directed to start LLFS.[31] The LLFS functions in all hospitals with 100 or more beds and the services are available for 24 hours.

(V) Re-organization and re-structuring of existing system

A. Drug Policy & Procurement system

Drug policy and procurement reforms consist of formulation of an Essential Drug List (EDL) and directions for implementation. The genesis of drug policy and related reforms in Rajasthan can broadly be traced to the organization of a workshop on rational use of drugs in 1998. Based on the recommendations of this workshop, a committee was formed to develop an EDL. The EDL was then finalized and began to be used for procurement[32]. The EDL, first developed in 2000 is presently being revised. The standard treatment

[30] GO No. F.14(1) M&H/1/97/2 dated 21.10.2000
[31] Vide a Department letter dated 3 September 1996.
[32] GO No. F.22(15) Med./74 Pt. dated 6.3.2000 and GO F.22(15) Med.2/74 Pt. dated 27.3.2000

guidelines (STGs) have also been developed and are currently under notification. In terms of procurement, centralized approval is sought and procurement is undertaken at the districts. Available drugs are purchased from Rajasthan Drugs & Pharmaceuticals Limited at an institutional price while for the remaining, tenders are invited from other PSUs and decision is made through a two-bid system.

B. Creation of Rajiv Gandhi Population Mission[33]

The Rajiv Gandhi Population Mission was created in 2001 under the chairmanship of the Chief Minister, in compliance of the Cabinet decision 68/2001, dated 20-21 June 2001. The Mission seeks to enhance the effective implementation of the Rajasthan State Population Policy-2000. It also seeks to optimally utilize the opportunities created through Panchayati Raj, enhance public-private partnership for improving the availability and accessibility of health services to the people. The strategies to be utilized include increasing access to reproductive health and family planning services through social marketing, creating demand for reproductive health and family planning services, ensuring effective inter-sectoral collaboration, effective implementation of legislation; concentrating on the unmet need for reproductive and child health and family planning and improving quality of care. The Mission is headed by a full time Mission Director and Secretary to the Chief Minister is the Mission Co-ordinator. An Empowered Committee supports the Mission while a Technical Support Group assists the Mission Director.

In order to ensure need based, area specific interventions, decentralized programme management forms the cornertone of the Mission. The health and population programme management has been decentralized to the PRIs. Annual plans at the village, sub-centre, PHC and district levels are being prepared with the active participation of the community and functionaries of related departments at the respective levels. Local capacity building for decentralized participatory planning has also been created. The PRIs are responsible for approval, implementation and monitoring of the performance of the programme.

(VI) Innovative Schemes & Programmes

A. Jan Mangal Programme[34]

The Jan Mangal Programme was started to promote the health of the mother and child through proper spacing between births. The programme first began in 1992-93 in Udaipur and Alwar districts of Rajasthan. Based on the spirit of volunteerism, the programme is routed by a husband-wife couple at the village level. These couple volunteers are identified as Jan Mangal Couples (JMC). One JMC is selected for every village having a population of 500 to 1,000 while two JMCs are selected for villages having population between 1,000 – 2,000. The selection of JMC is undertaken by ANMs by contacting opinion leaders, elected representatives, ICDS worker, Nehru Yuva Kendra (NYK) members and adult education teachers. Based on the list provided by the ANMs, the final selection is done by Deputy Chief Medical and Health Officer (Family Welfare) at the district level. The stipulated criteria is that the couple resides in the village, enjoys credibility in the community,

[33] Govt. of Rajasthan (2001), Mission Document: Rajiv Gandhi Population Mission, Medical, Health & Family Welfare Dept.

[34] UNFPA (2003), Community based programme for improving health of mothers & children: Jan Mangal Programme in Rajasthan

is willing to work as volunteers, fall into the age group of 25 to 35 years, is functionally literate and are preferably users of any contraceptive method.

With a view to capacity building, a three-tier training design of three days duration at every level has been adopted for the JMC.[ix] The Block level trainers (BTTs) conduct the trainings of JM volunteers at the PHC level. All the selected JMCs are trained for three days on issues related to maternal morbidity and mortality due to frequent pregnancies, its ill effects on child health, the need and benefits of using spacing methods, knowledge on use of method and their likely side effects. They were also briefed on the objectives of the JM Project, implementation and monitoring mechanisms to be adopted and to address problems faced by JM couples in their course of work.

A simple reporting format has been developed for the JMCs, wherein emphasis is laid on initial use of pills and condoms, continuation, side effects and dropouts. At sector PHC level, a bi-monthly meeting called 'milan baithak' is held wherein the JMCs share reports, replenish supplies and seek information on specific problems of users. The meeting is also used for continuing education sessions, distribution of communication material, information about health/RCH camps and disbursement of wage loss and travel expense. These meetings are addressed by Medical Officers of concerned PHCs, JM Coordinator, LHV and ANMs also participate in the meeting. JMCs bring their reports to the bi-monthly meetings, which are then compiled first at the PHC level, and then at block PHC level for onward transmission to the district. At the district level, JM Coordinator prepares a consolidated report which is sent to the state level. Information regarding attendance in these meetings and number of JMC dropping out of the programme is also compiled in these meetings. As most of the JMCs are daily wage labourers, they are paid an amount of Rs 100 per volunteer to compensate for their wage loss and travel expenses to participate in the bi-monthly 'milan baithak'.

The Jan Mangal programme is managed through an autonomous body - the State Health and Family Welfare Society for Voluntary Sector, Registered under the Societies Registration Act, under the chairpersonship of Secretary (Family Welfare), Govt. of Rajasthan. The Director Medical, Health & Family Welfare Services is the Member Secretary. Considering the scale and intensity of operations, a coordination unit (CU), headed by a NGO person, designated as State Coordinator, was set up at the state level in February 1997. The unit was responsible for development of comprehensive action plan, implementation, initial training, material development, budget finalisation & guidelines for its utilisation, carrying out base line and monitoring of district Jan Mangal activities. However, contractual positions in the state PMU have been discontinued since 2001 and the project is being managed by the Demography Cell, DoFW. District level Jan Mangal coordinators have been placed in all the districts. It was also thought that the district level co-ordinators should not work as separate identity but be made part of the larger delivery system. Such integration could have, in case of dearth of time and resources among the district officers, ensured utilizing the district coordinators for monitoring the quality of project activities.

The Jan Mangal Programme has ensured ready availability and accessibility of OCPs and condoms in remote villages and also facilitated the creation of a large community based volunteer cadre. The total number of JMCs in all 32 districts, as of March'03, was 28,303. As per the report of GoR, upto March'03, the JMCs were catering to total 2,41,817 users of condoms and oral pills. In spite of such successes, there have also been some constraints in programme implementation.

It has been seen that the ANMs perceived the JMCs, as competitors rather than facilitators, and hence did not supply contraceptives to them on field visits. The mid-course assessment undertaken, studied the conduct of the *Milan Baithak*s. The interest shown by the doctor and supervisor in holding *Milan Baithak*s was found to be poor. They also did not encourage the JM couples to pose questions, clear doubts and reinforce knowledge. The role of the supervisors in this regard was perceived to be better. The JM couples complained that time spent in *Milan Baithak*s was long. The project suffers from some of the usual constraints within the system such as lack of timely provision of funds, ensuring proper conduct of *Milan Baithak*s, inculcate interest among the doctors and district level officials in supporting and monitoring the project activities. Some of the lessons learnt, include need to improve the management of the programme, the need for reorientation of JMCs; identification of JMCs by giving them a bag and recognition of JMCs by organising district level programme. The JM project was initiated for a period for two years after which an assessment was undertaken. This was in addition to the monitoring visits undertaken at periodic intervals, review of receipt of MIS reports and discussions with district officers. The UNFPA also sponsored an evaluation study at the end of 1995. This study was carried out by the independent agency Media Research Group with a view to ascertain the overall effectiveness of Jan Mangal programme in Alwar and Udaipur districts. The results of the study revealed that Jan Mangal volunteers motivated a significant number of couples. Some of the problems discovered were maintaining volunteer's continuity in milan baithaks, tie up with gram panchayats, maintenance and dispatch of records/report. The evaluating agency recommended more intensive training of Jan Mangal volunteers, ensuring well designed milan baithaks, regular supply of contraceptives and timely payment of wage loss. It also recommended publishing a newsletter on Jan Mangal issues.

B. Equity Enablers

Equity Enablers includes the BPL Medicare Card Scheme being implemented by the State. About 23 lakh cards have been distributed. 25 percent of funds raised under the MRS are utilized for purchase of drugs for BPL patients. This is in addition to the drug budget of the health institutions.

C. Mukhya Mantri Jeevan Raksha Kosh

Given the high cost medical facilities, their inaccessibility to persons living below the poverty line, the Mukhya Mantri Jeevan Raksha Kosh, was started to provide cent percent financial assistance to the poor for diagnosis and treatment of serious ailments including cancer, heart disease, kidney and thalesammia. Upto June 2004, 3613

persons had benefited with a financial assistance of Rs. 1678 crore under this initiative.

(VII) Other Policy Initiatives

In the arena of policy reforms, the following policies have been framed. These are Population Policy & RG Population Mission, training policy, essential drug policy, policy to promote private sector and transfer policy amongst others. Health Vision 2025 is being worked upon. Some of the other policies under consideration are formulation of a State health policy, anti quackery bill, clinical establishment Act and regulatory authority for health care and medical education.

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[i] **Regulation of the private sector-**
Attempts have been made towards the enactment of the Rajasthan Clinical Establishment Regulation Bill, 2001/ 2002

[ii] For investigative/diagnostic machines, licensee can avail of space in the hospital building to install the machine, provided that s/he maintains and operates the equipment as per conditions laid out in the license. The MRS invites open tenders, with the tenderer being required to quote annual license fees and rates per tests separately in the bid. The licensee is required to pay a monthly rent of Rs. 5000 per month to RMRS, provide upto 20% of the tests free of cost for categories specified by the Govt and bear all expenses on account of electricity, water, maintenance, etc. The offers received are then evaluated by the Secretary of the MRS and placed before the Governing Body for final decision.

[iii] For treatment machines like lithotripsy, cath lab, etc which are to be operated by the doctor themselves would be purchased by RMRS through bank loan for which necessary bank guarantee would be made available by the Finance Department. These machines would be operated on self financing basis by RMRS and the rates for procedure would be fixed in a manner that payment of load is made in time.

[iv] In the policy statement, the government specified the need for development of effective secondary and tertiary care system. It acknowledged the financial crunch faced by the government and the need for efficiency and better clientele servicing. These were specified as reasons for involving the private sector in health care. In order to attract investment from private providers in speciality services and curative care, the GoR has categorized bidding institutions into four categories. These are:

- *Category A:* Charitable medical institutions (non-profit organisation) willing to set-up at least one advanced diagnostic or curative services by acquiring medical equipment from the approved list of state government or offering speciality services as per the plan approved by the state government.
- *Category B:* Charitable medical institutions having their own plan to set-up health facilities.
- *Category C:* Institutions (registered firms, societies, trusts) interested in setting-up speciality hospital in specialities approved by the state government and in particular geographic region.
- *Category D:* For-profit organisations (nursing homes providing maternity and child care facilities having at least 10 beds and OPD facilities, hospitals having at least 50 beds and OPD facilities, diagnostic centres).

The policy instrument of the GoR includes providing land at subsidised rates and provision of other fiscal benefits to institutions interested in setting-up health facility. The subsidy varied according to categorisation defined above and depended on whether the facility was to be set-up in rural or urban area. Further to this, GoR also provided fiscal incentives on all purchases of medical equipment, plant and machinery provided they are from approved list of DoHFW and facilities set-up before 31 March 1999. These incentives were as follows:

- Exemption from payment of sales tax on purchases of medical equipment, plant and machinery;
- Exemption from payment of octroi on medical equipment, plant and machinery, whether imported or gor from other states.
- Other fiscal benefits from state level and other financial institutions as per the provisions of those institutions.

A specific time frame of two years from the date of allotment was laid for the use of allotted land. The Government constituted a broad-based empowered committee to screen all bidding proposals and for short-listing and final selection of institutions. Most of the related department secretaries, including inter-alia, Secretaries from Departments of Finance, Health, Industry, Revenue, Urban Development and Housing were members of this committee. The response to the policy initiative of GoR was reasonable. In all 14 proposals were received. Each bidding institution was required to submit an application along with project feasibility report and proof for the sources of funding to set-up the project.

In terms of implementation, despite having a comprehensive policy on private participation, the final clearances and allotment decisions faced number of procedural difficulties. Since no locations were identified before the start of the process, the implementation of policy had to work out the details of available locations. For this purpose, the preferences from each bidding institution were collated first. The Committee forwarded this information to respective development authority or to the Municipal Corporation. Since the number of development authorities and municipalities involved were too many, it became difficult to co-ordinate the whole process. Each agency was required to come up with detailed information about the possible sites of the required sizes. This process resulted in applicant getting number of options of land locations for his proposed project. This created a bit of confusion and led to delays in decision making. The government also experienced time delays in implementing the policy due to the problems faced in getting number of clearances from various departments. Authorities were not prepared to implement and give clearances as there was no agreement on how the losses will be shared across the departments. It also created procedural difficulties in implementing the policy because most of the developmental authorities were selling these properties through auction. This was seen as major departure from set procedures and there was reluctance to depart from existing practices.

Source: Bhat Ramesh (1999), "Public-private partnerships in health sector: issues and prospects", Second revised draft, IIM-A

[v] The Society includes representatives from the district level heads of Education, WCD, NGOs, 2-3 eminent citizens, Pradhans of Panchayat Samiti, 3-4 members of Women
's Forum, State PMU Representative, Dy. Project Coordinator and UNFPA representative. The GB is scheduled to meet at least once each quarter and is responsible for annual plan finalization, activity monitoring and inter institutional coordination.

[vi] The EC has district level heads of Health, Education, WCD, representatives of the Collector, elected representatives comprising of at least 50% women representatives, 2-3 NGOs, 2-3 eminent persons (who may be familiar with the district), members of women 's forum, State PMU representative, Dy. Project Coordinator and UNFPA Representative.

[vii] The Management structure at Jaipur comprises of the Secretary, Medical and Health as the Chairman, the Divisional Commissioner as Vice Chairman, the Superintendent Medical College as Member Secretary amongst others. The structure is replicated similarly at the regional and district level.

[viii] It also commissioned two studies in the year 1997-98 and 2002-03, to assess the impact of MRS on quality of health services. The details of the same are being ascertained.

[ix] The state level team has trained district level resource persons known as District Training Team (DTT), which comprises of 12 resource persons (six men and six women) - Dy CMHO (FW), DMCHO/DRCHO, EPO, two MOs, two LHVs, Project Director-District Women Development Agency/Block Extension Educator, four NGO representatives. The DTTs then organised training of block level trainers (BTT) who were sector PHC MO, LHV and NGO representative. DTT and BTT were developed to eventually train the JM Volunteers. DTTs and BTTs were equipped with necessary training and communication skills, supervisory and monitoring procedures to train the JM couples in-turn and to manage the programme.

Annexure

Profile of Rajasthan

Population	
Population (millions) (2001)[1]	56,473,22
Estimated Urban Population (%) (2001)[2]	23.38
Scheduled Caste population (%) (2001)[1]	17.2
Scheduled Tribes population (%) (2001)[1]	12.6
Vital Statistics	
Life Expectancy at birth (Male) (in years) (1996-2001)[3]	60.32
Life Expectancy at birth (Female) (in years) (1996-2001)[3]	61.36
Total Fertility Rate (per woman) (1999)[3]	4.2
Sex Ratio (females per 1000 males) (2001)[1]	922
Birth Rate (per 1000 population) (2002)[4]	30.6
Death Rate (per 1000 population) (2002)[4]	7.7
Socio-Economic Profile	
Literacy Rate (total) (%)(2001)[1]	61.03
Net State Domestic Product (2000-01)(P) (Rs. in millions) (at current prices)[5]	701430
Main workers to total population (%) (2001)[3]	30.86
Population Below Poverty Line (%) (1999-2000)[6]	15.3
Water, Environment & Sanitation	
Households having access to safe drinking water (%)(1991)[7]	58.96
Households with no toilet / latrine facility (1998-99)[8]	71.8
Health Status	
Infant Mortality Rate (per 1000 live births) (2002)[3]	78
Deliveries assisted by a health professional (1998-99)[8]	35.8
Health Infrastructure	
Number of Medical College Hospitals (MCH)[9]	7
Number of District Headquarter Hospital (DHH)	NA
Number of Total Allopathic Hospitals (As on 1.1. 2001)[10]	215
Number of Community Health Centres (CHC) (As of 31.03.2001)[11]	297
Number of Primary Health Centres (PHC) (as of 31.03.2001)[11]	1675
Number of sub-centres (SC) (As of 31.03.2001)[11]	9926
Health Financing	
Total Health Expenditure as % of total expenditure (Rs. in Millions)	NA
Public Expenditure on Health (Total) (Rs. in Millions) (2000-01)[12]	90299
Per capita public health expenditure (Rs. in Millions)	NA

[1]Census of India, 2001
[2]Urban Statistics Handbook, 2000
[3]SRS, RGI
[4]SRS, RGI, 2002
[5]Directorate of Economics & Statistics
[6]Planning Commission
[7]Census of India, 1991
[8]NFHS-2
[9]DMHS, 2003-04
[10]Health Information of India 2002
[11]Health Information of India 2000 & 2001
[12]State Finances, RBI

Tripura

TRIPURA

Tripura is a state, where a combined culture is scripted by tribal and non-tribal communities. This State is named after Goddess Tripura Sundari (or Tripureshwari). The state has an area of 10,491.69 sq. km and is administratively divided into 4 districts. It is mainly a hilly territory with altitudes varying from 50 to 3080 ft above sea level, though the major population of the state lives in the plains. Today, Tripura is largely a Bengali community, inspite of the 19 Scheduled Tribes that form more than 40 percent of the state's population.

Agriculture is the mainstay of the economy;shifting cultivation is gradually being replaced by modern farming methods. Important cash crops are tea, jute, cotton, and fruit. Wheat, rice, potatoes, and sugarcane are also grown. Almost half the land area is still covered by forest. The Government of India has recently taken a number of initiatives to develop infrastructural facilities in Tripura and other North-eastern states.

The Government of Tripura traces the genesis of reforms to rapid socio-economic changes, demographic and epidemiological transitions and the changing global scenario. Through the reform measures, the government seeks to provide health servicesat the doorstep of the people as well as to generate awareness amongst them.

Reform Initiatives[1] include:

(I) Public Private Partnership

A. Contracting out of select services

The Government of Tripura has entered into an agreement with Sulabh International, Agartala branch for upkeep, cleaning and maintenance of the G.B hospital and the surrounding area. The contract is valid for a period of three years commencing from August 1, 2001. The terms and conditions laid down in the contract stipulate the total area to be cleaned, the number of times it would be cleaned and the time of the day when these activities would be carried out. The authority would pay a mobilization advance which is equivalent to one month value of the contract. The agreement clearly states that the government and its workers would retain the right to access the premises and for execution of the contract. In case of any lapse or neglect on part of Sulabh International or if otherwise decided, the agreement can be terminated. In case of untimely termination, the organization is liable to refund the advance together with interest at 9% per annum and to pay compensation equal to double the advance given to the organization. In event of non-performance of work by Sulabh International, the authority would make proportionate reduction of agreed amount. In case of any dispute, the decision of the Commissioner (Health), Govt. of Tripura is considered final. The super-speciality services at the GBP Hospital have been entrusted to a society which includes representatives of Care Foundation, Hyderabad and officials of State Government of Tripura.

(II) Reforms related to Human Resources

A. Deployment of staff

A Steering Committee chaired by the Chief Secretary, Government of Tripura, Advisor (Rural Development), Planning Commission, representative of UNDP and other concerned members, has been set up. The first meeting of the Committee has been held. The necessary data for preparation of Tripura Human Report is underway.

With particular reference to the Health & Family Welfare Department, the report of another Committee

[1]Govt. of Tripura (2003), Response to Questionnaire on Health Sector Reforms from GOI

headed by the Chief Secretary has been received. This report has laid down the scale of deployment of manpower in different health institutions based on population coverage, inaccessibility, etc. This report has been examined and accepted in the Department. The implementation of the same requires creation of a good number of additional posts. The process for this has been initiated but it is likely to take some more time before additional posts are available.

Furthermore, with a view to help improve coverage and ensure widespread implementation of national programmes, ISM&H practitioners are being main-streamed.

(III) Changes in Financing Methods

A. Levying of user fees in hospitals and establishment of pay clinics

In the state of Tripura, user fees have been levied in Govind Ballav Panth (G.B) Hospital and Indira Gandhi Memorial (IGM) hospital since 1992. As part of this, the Governor of Tripura has issued various letters / orders introducing registration fee at OPD and admission fee for those advised hospitalization[2]; introduction of charges for undergoing investigation in ultrasonography and ECG in hospitals of the state[3]; charges for dialysis and TMT[4]; for investigation of endoscopy[5] as well as for ultrasonography and ECG.[6] The cabin charges including the charges of x-ray, pathological investigations and blood bank services along with other hospital charges were revised as per the decision adopted in the meeting of the Council of Ministers held on July 15, 1992.

B. Granting of Autonomy to Hospitals and Health Institutions

Autonomy has been given to CARE at GBP Hospital, C.C.U at T.S. Hospital, Udaipur. A proposal for granting further autonomy to four State Hospitals (Govind Ballav Path Hospital, Indira Gandhi Memorial Hospital, Dr. B.R.Ambedkar Hospital and Cancer Hospital) is under consideration. Presently, all these hospitals have independent budget allocation and authority to make procurement of medicines, equipment as also to incur expenditure for maintenance of equipment and upkeep of hospital after following prescribed financial procedure. The mater of whether hospitals would be allowed to levy user charges for more services and bring back the earnings to meet operating costs is under examination.

(IV) Re-organization and re-structuring of existing system

A. Merger, Restructuring & Re-location

Merger, restructuring, relocating of taluk, sub-divisional and rural hsoptials, dispensaries and block level and their integration with the existing infrastructure so as to fill in the gaps in CHCs is under consideration.

B. Formation of Hospital Development Committees

Health institution is a property of the community. Benefits that flow out of a health institution go directly to the people of the community. Active participation of the community, especially for maintenance and day-to-day management of health institutions, is an essential requirement. Users need to have a stake in the functioning of health

[2] F.2 (13) Med/92 dated 23.9.92
[3] F.1 (733)-MS/GS/96, dated 22.5.1996
[4] F.2(59)-MED/GEN/92-99 dated 24.1.2000
[5] F.3(48)-MED/96-97 (Sub) dated 6.11.2001
[6] F.1(733)-MS/GS/96 dated 22.5.1996

institutions. Through involvement of the community only it is possible for the Government to maintain, manage and run the health institution to deliver optimum level of services on a sustained basis. With this objective in view, it has been decided to form Health Development Committees from Sub-Centre level to District level. Modalities about implementation of this concept are being worked out.

Annexure

Profile of Tripura

Population	
Population (millions) (2001)[1]	3.191
Estimated Urban Population (%) (2001)[2]	17.02
Scheduled Caste population (%) (2001)[1]	17.4
Scheduled Tribes population (%) (2001)[1]	31.1
Vital Statistics	
Life Expectancy at birth (Male) (in years) (1996-2001)[3]	NA
Life Expectancy at birth (Female) (in years) (1996-2001)[3]	NA
Total Fertility Rate (per woman) (1999)[3]	NA
Sex Ratio (females per 1000 males) (2001)[1]	950
Birth Rate (per 1000 population) (2002)[4]	17
Death Rate (per 1000 population) (2002)[4]	5.7
Socio-Economic Profile	
Literacy Rate (total) (%)(2001)[1]	73.66
Net State Domestic Product (2000-01)(P) (Rs. in millions) (at current prices)[5]	48690
Main workers to total population (%) (2001)[3]	NA
Population Below Poverty Line (%) (1999-2000)[6]	34.4
Water, Environment & Sanitation	
Households having access to safe drinking water (%)(1991)[7]	37.18
Households with no toilet / latrine facility (%) (1998-99)[8]	
Health Status	
Infant Mortality Rate (per 1000 live births) (2002)[3]	49
Deliveries assisted by a health professional (%) (1998-99)[8]	NA
Health Infrastructure	
Number of Medical College Hospitals (MCH)	NA
Number of District Headquarter Hospital (DHH)	NA
Number of Total Allopathic Hospitals (As on 1.1. 2001)[9]	27
Number of Community Health Centres (CHC) (As of 31.03.2001)[10]	11
Number of Primary Health Centres (PHC) (as of 31.03.2001)[10]	58
Number of sub-centres (SC) (As of 31.03.2001)[10]	539
Health Financing	
Total Health Expenditure as % of total expenditure (Rs. in millions)	NA
Public Expenditure on health (Total) (Rs. in millions) (2000-01)[11]	8628
Per capita public health expenditure (Rs. in millions)	NA

[1]Census of India, 2001
[2]Urban Statistics Handbook, 2000
[3]SRS, RGI
[4]SRS, RGI, 2002
[5]Directorate of Economics & Statistics
[6]Planning Commission
[7]Census of India, 1991
[8]NFHS-2
[9]Health Information of India 2002
[10]Health Information of India 2000 & 2001
[11]State Finances, RBI

Uttaranchal

UTTARANCHAL

The State of Uttaranchal was created on 9th November 2000 by combining the districts of Uttarkashi, Chamoli, Rudraprayag, Pauri, Tehri, Dehradun, Pithoragarh, Champawat, Nainital, Almora, Bageshwar, Hardwar and Udham Singh Nagar. The districts have been grouped into two distinct divisions on the basis of homogeneity, contiguity and socio-cultural affinity. These are the Garhwal Division and the Kumaon Divison.

Uttaranchal has a population of 8.5 million. The state has 13 districts, 49 *tehsils*, 95 blocks, and 16,414 villages with about 78% of the population of the state living in rural areas. About 36% of the state's population is younger than 15 years and only 5% is aged 65 or above. The overall literacy rate is as high as 72%. The state, being a hilly one, is the most sparsely populated state in the country with a population density of 159 per sq. kms. The poor road connectivity, difficult hilly terrain (93% of area in hills), small scattered settlements lack of infrastructure and humanpower contribute to problems of access to health service delivery. Given the poor paying capacity and scattered location of settlements in hilly districts, the population is almost entirely dependent on the public health delivery system while the presence of the private sector tends to be concentrated in the plains.

Reform initiatives[1] include:

(I) Public Private Partnership

A. Privatization of Sanitation, Laundry & Diet Services

With a view to improve health service delivery, the Government of Uttaranchal has handed over laundry and diet services in 9 big hospitals to private agencies in December 2001 while those in Doon Hospital were handed over in February 2003. These agencies have been selected on the basis of competitive bidding.

(II) Decentralization

A. Delegation of powers under 73rd Amendment to Panchayati Raj Institutions (PRIs)

As part of decentralization, powers have been delegated to PRIs wherein the health service delivery personnel of allopathic system of medicine will be answerable to the PRIs in addition to their parent department. The financial and administrative powers have been delegated to PRIs at all three levels. Simultaneously, the responsibility of implementing all National Programmes has also been entrusted to them.

The Gram Panchayats now have administrative control of male & female workers at village level while the block panchayat would have administrative control over all health delivery personnel at the block level. It is stipulated that future recruitments are made through the Gram Panchayat and the Block Panchayat. The Chairman of the Zilla Parishad would have administrative control at the district level with the CMO functioning as an Additional Executive Officer.

B. Establishment of an inntegrated umbrella society at state and district level

With the purpose of tackling management issues, an pex society for National Programmes has been formed

[1] Govt. of Uttaranchal (2003), Power-point presentation on 'Health System Reforms in Uttaranchal' at workshop on India's Health System: Role of Health Sector, September 4-5,2003, New Delhi.

under the Chairmanship of Chief Secretary for speedy implementation of National Health Programmes. The Principal Secretary, Medical Health & Family Welfare is the Vice President while the Director General is the Member Secretary for the Empowered Committee. The other members include, Secretaries from Finance, Education, Urban Development, Women & Child Welfare and Rural Development. The Society has seven State-level Executive committees for each of the six national programmes, namely, Blindness, Tuberculosis, Leprosy, RCH, Malaria and AIDS and also for the Sector Reform Cell.

The composition of each of these six committees includes the Secretary, Medical Health & Family Welfare as Chairman, the Director General as Vice Chairman & the State Programme Officer responsible for a particular programme as a Member Secretary. The Executive Committee formulates plans, monitors and evaluates the performance of the programmes and is responsible for financial allocations that are distributed to the respective district-level societies. n A secretariat, fitted with personnel and equipment has been set up to provide support to this initiative. A State SCOVA Secretariat as well as Sector Reform Cell Secretariat has been established at Dehradun wherein the Additional Secretary, Medical Health & Family Welfare is assigned the additional responsibility of Executive Director.

The State government is merging the various vertical societies to create an integrated umbrella society at the district level. A District Empowered Society has been registered in each district. This committee is headed by a District Magistrate with the CMO functioning as a Vice-President, a Programme Officer (PO) and representatives from the NGOs and private sector. The PO is responsible for the day-to-day management of a programme. The funds would flow from the Govt. of India through the State level society to the District Empowered Committees for implementation of National Health Programmes. A Secretariat, manned with personnel and equipment provides support to this initiative in each district.

(III) Reforms related to Human Resources

A. Appointment of Medical Officers & ANMs on contractual basis

With a view to improve access to health services in remote areas and given the difficulty in retaining services of various service providers due to lack of accommodation and low salary, contractual appointments of medical officers and ANMs are being made. This initiative has been in place and 187 Medical Officers & 258 ANMs have been appointed on a contract basis. Contractual appointment of 300 Medical Officers is under process and is likely to be finalized shortly in order to ensure availability of medical officers in un-served and under-served areas, the Government has increased the honorarium of contractual Medical Officers from Rs. 11,000 per month to Rs. 13,000 per month with effect from February 6, 2004.

As part of the RCH programme too, contractual staff has been appointed. This includes 44 Lady Medical Officers (LMOs), 52 staff nurses, and 370 additional ANMs. Furthermore, in order to promote institutional

deliveries, 24-hour delivery services are being provided in 85 health centres and certain incentives are proposed for service providers who conduct deliveries between 8.00 p.m. to 7.00 a.m. A proposal for the release of grant-in-aid for 24-hour delivery services under the RCH programme is to be received from the GoI, Ministry of Health. Also, doctors, nurses, and clearing staff are paid an honorarium at the rate of Rs 200, 100, and 50 per delivery, respectively.

B. Transfer Policy for Medical Officers & special salary for doctors in remote areas

A similar objective of improving access of the population in remote areas to health services and ensuring the availability of services providers in such areas, had led to the development of a transfer policy for Grade 'A' and Grade 'B' Medical Officers[2].

The service providers serving in remote areas are given soft postings & vice-a-versa. Furthermore, mnedical officers posted in remote areas are given preference for PG admissions during service. A special non-practicing allowance is being given to doctors posted in remote & difficult areas[1]. It is hoped that such an initiative would assist in retaining doctors in such areas and thereby improving access of the population in such areas to health care services.

C. Fixing roles & responsibilities of Medical Officers at Additional PHCs & SADs

With a view to tackle management issues, the roles and responsibilities of Medical Officers at the Additional PHC have been fixed. As per this stipulation, the MO in-charge of the Additional PHC would function as a controlling officer for all service providers at the sub-centers and for all the health supervisors working in their territory. The MOs in charge of the SADs, co-ordinate with the MO in-charge of the Additional PHC in discharging their duties. Similarly, an integration of ICDS with the Medical Department is underway at the level of Additional PHC.

D. Integration of ISM&H practitioners in National Programmes

After coming into existence, Uttaranchal decided to establish an Ayurveda, Unani, and Homeopathy Directorate on 1 August 2001. Since these three systems of medicine have had a long presence in the state, especially in the remote rural areas, an attempt is currently underway to use their potential for improving accessibility to health services. Under this initiative, the sn ervice providers of ISM&H participate in the implementation of the National Health Programmes. Linkages have been established between the ISM&H and health department at the sector, block and district levels. Tn he ISM&H service providers make available monthly reports to the

[2] For Grade 'A' officers, the maximum limit in one place is 2 years for Joint Director Grade and 5 years for Class I officer. The specialist will be transferred after getting his/her substitute. The transfer will be done from soft (easy) places to difficult / hilly places and vice-versa. The person is required to stay in hilly area for 3 years. Easy / plain posting will be given after completion of three years difficult / hilly posting. For Grade 'B' officers, the transfer policy is applicable to those who have served maximum for five years in one place and have been serving in the same district for maximum seven years. There is no restriction in posting of home district. Specialists will be posted at CHCs, Tehsil level and district hospitals as per requirement of the post. Those who have completed 5 yrs in difficult / hilly place will be posted at easy / plain area. Preference in PG admission would be accorded to those who service difficult / hilly area.

Directorate through the Chief Medical Officers. nIt is proposed that these officers are trained and involved in the provision of primary health care services, including the RCH services. It is also proposed that they be entrusted with the supervision of sub-centres.

(IV) Changes in Financing Methods

A. Formation of nChikitsa Prabandhan Samittee in select hospitals

With a view to bring about decentralization, encourage communication participation and improve health service delivery, Chikitsa Prabandhan Samitees have been registered for 30 district level hospitals under the chairmanship of district magistrate. 100% retention of user charges is made by the Chikitsa Prabandhan Samitee. Besides these 30 hospitals, health institutions in the public sector at the block PHC level and above have the right to retain 50 percent of user charges collected for better of health service in the hospitals.

(V) Re-organization & re-structuring of existing system

A. Integration of health programmes with ICDS programme

With the objectives of combating the problem of access to health services, extending the reach of health services to remote and underserved areas and to bring about convergence in the programmes of the health department and the ICDS, the Angandwadi workers (AWWs) have been given orientation training to register ANCs & refer high risk cases. The Health & Family Welfare Department along with the Department of Women Empowerment & Child Development have issued an order in this regard. The order delineates the convergence schedule of the health and ICDS staff, right from the ANM-AWW level to the DPO-CMO level [3].

B. Establishment of a fixed day schedule for health service delivery

With the aim of ensuring better management of human resources, ensuring the availability of health service delivery to clients and ease in monitoring, a fixed day schedule has been drawn for providing services across the state of Uttaranchal.[4]

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[3] At the village level, the Department has deputed the ANMs at the sub-centres, each of which covers roughly 4-10 villages. These villages are covered on a fixed day approach. Every Wednesday would be observed as the sub-centre day and pro vide immunization services while every Saturday would be observed as outreach day. The tour schedule of the ANM has also been fixed for both the plains and hilly areas. In order to ensure that adequate attention is paid to the cases referred by the AWW, a system of issuing referral slips has been proposed to be developed by the ICDS project. At the sector level (on every 3rd Friday), the established PHC/ Additional PHCs would conduct a monthly meeting to be attended by the LHVs, ANMS, AWWs and MS. This meeting would be presided by the MO and the concerned CDPO. At the block level (on every 4th Friday), the monthly meeting would be presided by the DPO and CMO ensuring that each block is covered by rotation. The MOs, LHVs, CDPOs and MSs of the block would attend this meeting. At the district level (on every 1st Monday) a similar meeting would be held at monthly intervals. All MOs, CMOs, CDPOs and DPO of the district would participate. At the State level, the Director ICDS would interact with the DG (Medical Health & Family Welfare) and Additional Director (National Programmes) to ensure smooth co-ordination between the departments.

[4] The fixed days for service delivery include Tuesday as sterilization day at District level hospital, Wednesday as sub-centre day, Thursday (once a month) as RCH camp day at block level PHC, 3rd Friday of month as sector meeting, 4th Friday of the month as meting of block PHC, Saturday & Monday as RCH outreach session day, 1st Monday as meeting at District Headquarter, every Tuesday as school health examination day.

C. Health service delivery through community sponsored candidates

A pilot project is presently being planned with the support of the Sector Investment Programme for provision of primary health service delivery, awareness generation and distribution of ORS, contraceptives, etc through community participation in two blocks of Jaspur, U.S.Nagar and Pratapgarh in Tehri District with the Himalayan Institute Hospital Trust (HIHT) functioning as a mother NGO.

D. Provision of Mobile Van for Curative Services

In the realm of public-private partnership, reform initiatives include provision of mobile van for diagnostic and curative services in the Kumaon and Garhwal division. This initiative is being undertaken with the support of TIFAC (Technology Information Forecasting & Assessment Council) under the Department of Science & Technology, GOI. As per the agreement, the Govt. of Uttaranchal would bear half of the operational cost for this initiative. The mobile van in turn would be operated by the Birla Institute of Scientific Research, Bhimtal. Furthermore, the Government has sanctioned a multi-utility mobile van project under the Sector Investment Project. This project will be implemented by the Hindustan Latex Ltd (HILL), who will provide preventive and curative services in Chamoli district of Garhwal region.

E. Development of a Drug Procurement Policy

The objective of improving the quality of available drugs, has led to the development of a drug procurement policy. In September, 2001, the State Government issued an order setting out the procedure to be adopted for procurement. The process laid down, necessitated that the procurement is done through a Central Committee headed by DG, Health Services, with Assistant Director (Stores) as the Member Secretary. This Committee is responsible for drawing up a list of items to be procured and would then obtain Government's endorsement before proceeding with further action. 80% of the drug budget would be placed at the disposal of the peripheral institutions (i.e. the districts and blocks) while remaining 20% of the budget will be at the disposal of the DG, Health Services for the purchase of special category drugs. The peripheral authorities can spend up to 15% of their budget allotment for procurement of items, which are not included in the rate contract. It is further stipulated that the company, which would provide drugs should have a minimum turnover of Rs. 15 crore in the past three years in addition to having abided by the WHO-GMP certification.

F. Establishment of Public Call Operator (PCO) in Government Hospitals

With an eye to enhance client convenience, the government of Uttaranchal has issued an order, supporting the installation of telephone facility in public hospitals by private PCO providers. These providers would be selected on the basis of competitive bidding for a period of three years. They would be required to pay rent to the hospi-

[i] A special non-practicing allowance (NPA) package is given to doctors in remote and difficult areas, in addition to the 20% NPA which is admissible to all. For those having a pay scale range of below Rs. 10,000, the special NPA, p.m. is Rs. 3000 in very difficult areas and Rs. 2000 in difficult areas. For those with salary >Rs. 10,000 – upto Rs. 12,000, it is Rs. 3500 and Rs. 2500 respectively while for those earning Rs. 12,000 and above, it is Rs. 4000 and Rs. 3000 respectively.

tals for usage of space. The users would pay for the calls at DOT rates.

(VI) Other Policy Initiatives

The Government of Uttaranchal has developed an integrated Health & Population Policy in December 2002. Specific policy directions and interventions have been enumerated in the policy.

Annexure

Profile of Uttaranchal

Population	
Population (millions) (2001)[1]	84.79
Estimated Urban Population (%) (2001)[2]	25.59
Scheduled Caste population (%) (2001)[1]	17.3
Scheduled Tribes population (%) (2001)[1]	3.04
Vital Statistics	
Life Expectancy at birth (Male) (in years) (1996-2001)[3]	NA
Life Expectancy at birth (Female) (in years) (1996-2001)[3]	NA
Total Fertility Rate (per woman) (1999)[3]	2.6
Sex Ratio (females per 1000 males) (2001)[1]	964
Birth Rate (per 1000 population) (2002)[4]	18.1
Death Rate (per 1000 population) (2002)[4]	6.4
Socio-Economic Profile	
Literacy Rate (total) (%)(2001)[1]	72.28
Net State Domestic Product (2000-01)(P) (Rs. in millions) (at current prices)[5]	NA
Main workers to total population (%) (2001)[3]	NA
Population Below Poverty Line (%) (1999-2000)[6]	NA
Water, Environment & Sanitation	
Households having access to safe drinking water (%)(1991)[7]	NA
Households with no toilet / latrine facility (%) (1998-99)[8]	NA
Health Status	
Infant Mortality Rate (per 1000 live births) (2002)[3]	44
Deliveries assisted by a health professional (%) (1998-99)[8]	34.6
Health Infrastructure	
Number of Medical College Hospitals (MCH) [9]	1
Number of District Headquarter Hospital (DHH) [9]	16
Number of Total Allopathic Hospitals (As on 1.1. 2001) [9]	391
Number of Community Health Centres (CHC) (As of 31.03.2001) [9]	36
Number of Primary Health Centres (PHC) (as of 31.03.2001) [9]	228
Number of sub-centres (SC) (As of 31.03.2001) [9]	1609
Health Financing	
Total Health Expenditure as % of total expenditure (Rs. in millions)	NA
Public expenditure on health (Total) (Rs. in millions) (2000-01)[10]	3422
Per capita public health expenditure (Rs. in millions)	NA

[1]Census of India, 2001
[2]Urban Statistics Handbook, 2000
[3]SRS, RGI
[4]SRS, RGI, 2002
[5]Directorate of Economics & Statistics
[6]Planning Commission
[7]Census of India, 1991
[8]NFHS-2
[9] Response from Directorate of Health Services
[10] State Finances, RBI

Another Beginning

ANOTHER BEGINNING

This document attempts to identify the content and process of health sector reforms across nine States in India. It is evident that States are trying to address issues pertaining to ensuring better health care delivery systems. While states are seeking to enhance the performance of their health care services, improve the health status of the population and the quality of people's lives, there is substantial variation across States in terms of their commitment to undertake reform and their capacity to implement them. It is evident that the nature and direction of health sector reforms are specific to each State, with each one being situated at a different juncture in the reform process. In spite of such divergence, common themes and approaches, objectives and issues can be identified across states. At the same time, it is a fact that in spite of being engaged in the reform process for over a decade, certain concerns and challenges face the Indian health sector and the stakeholders especially the policy makers. Against this backdrop, any attempt at generalization or drawing lessons would lend itself to oversimplification. However, some critical issues pertaining to health sector reforms in India need to be enumerated.

At the outset, there is a need to define and develop our own concept about health sector reforms in the Indian context. The questions we need to ask are, 'whether we are really engaged in health sector reforms or are innovations being undertaken in terms of health planning and provisioning of services.' There is a need to distinguish normal incremental changes from reforms. The current documentation is evidently a first step towards further work on this issue. It is crucial that policy makers at the State and Central level exchange experiences and information on health systems reforms, sound warnings, disseminate successes and draw lessons from the experiences of various States. Currently there exists no systematic mechanism for convergence of information pertaining to reforms across the various departments under the Ministry of Health & Family Welfare. The present work has brought out the necessity of ensuring a continuous process for sharing of reform initiatives and experiences between the Centre and the State, amongst the States as well as various departments and programmes under the Ministry. The Centre needs to act as a nodal agency and play a critical and proactive role in this regard. At the State level, this may necessitate assigning a nodal officer to co-ordinate health sector reform initiatives, holding workshops with officers and working towards ensuring that information about health sector reforms is included during preparation of Five Year Plans.

Sustained information and education on health sector reforms is also needed to generate wider political and public understanding and support for the reform process. Towards this end, regional resource institutions and persons need to be identified and / or inter-sectoral groups involving the key stakeholders established to support health sector reform. With more information being available about the dynamics and impacts of specific reforms, policymakers and programme managers can make appropriate corrections or move forward in successful directions. There is a need to promote research on health sector reforms. Researchable areas need to be identified and mechanisms need to be built to ensure effective linkages between research and policy making. This in turn would require developing an integrated system of surveillance, National Health Accounts, health statistics and assessing health system

performance. At the present juncture, it is pertinent to review the impact of current options and thereafter assess whether they could be implemented differently from the past as well as if required consider introducing substantive changes in different health sector entities and functions. A related area pertains to the development of relevant and accurate indicators which can be used for evaluation, for setting priorities and for guiding programmes at national, regional and local levels. This needs to be a collective activity involving the key stakeholders in the health sector reform process.

Ensuring successful implementation of reforms would require building capacities of individuals as well as institutions within the health system at each stage in the reform process. Government's capacity to undertake the critical function of overseeing the health sector needs to be further developed and utilized. In fact, the changing health sector scenario may necessitate re-examining the role of the government. Strengthening the institutional capacity of the states as also the implementation of health sector reforms in select states is another area which needs to be further developed.

The preparation of this document provided an opportunity not only to draw on secondary literature available on health sector reforms but also to interact with individuals from varied experiences and backgrounds. These included government officials across various States, programme officers and others at Directorates of various States, representatives from bi-lateral and multi-lateral agencies, experts, and representatives of various non-governmental organizations. Recognizing the need for further work in this issue, the Ministry is committed to undertaking certain activities.

Future Initiatives

One of the foremost planned initiatives would be dissemination of the current document across various States and stakeholders. A beginning could be made by having an in-house sharing of views and experiences at the Central Ministry itself (across and within departments). Regional level workshops are proposed to be held in collaboration with the States, with the dual objective of dissemination and collection of information about reform initiatives underway in other States. Simultaneously, to facilitate ongoing sharing of experiences across states, a web site would be developed.

Documentation of reform initiatives underway across various States is the first step towards enhancing our understanding of the impact of health sector reforms on access, quality, efficiency and equity relating to financing, organization and structure of health systems. Hence, with a view to provide evidence to policy makers, indicators would be developed to assess the impact of various reform initiatives as well as to enable comparison across States. Clearly, there are several issues which would benefit from additional analytical work. Therefore, issues pertaining to user fees, public private partnerships, contracting out have been identified for in-depth study.

Realizing the need for capacity building in this area, the Ministry would like to engage in some capacity building initiatives. This may take the form of preparation of operational guidelines on select reform initiatives like contracting out, involvement of PRIs in health and / or provision of technical assistance to the States.

To conclude, there is no unique answer as to what would be the best health sector reform option. If equity in access to basic health care must remain the goal, then the State cannot abdicate its responsibility in the social sectors. India would have to continue with a mixed model of government and private health care and evolve an optimal balance; the need to strengthen the state-sector would continue and at the same time it would be necessary to plan for a regulated growth and involvement of the private health sector as well. While on one hand, we need to take incremental and modest steps, at the same time, the stage needs to be set to address emerging challenges of making the health system more pro-poor, gender sensitive and user friendly. The system needs to be geared to respond to challenges posed by health transition, low levels of public investment in health, heavy reliance on out-of-pocket payments, sub-optimal functioning of the public health system and bring about improvements in health care services without substantially increasing the costs. The need of the hour is not merely to focus on identifying constraints but also on how to work around constraints that cannot be realistically changed. Whatever may be the nature of activity planned, future reforms need to emerge from continuing analysis, public discourse, and experimentation. If reforms with a 'human face' are to be carried out in India's health sector, the vision for change must come out of the discussions among the stakeholders in the health system. Any options which are agreed upon need to build in flexibilities to deal with the differing realities across States. The way ahead should be based on consultations, debates and by forging a consensus amongst policy makers both at the Centre and States as also other stakeholders and should aim towards increasing equity, efficiency, effectiveness, thereby, meeting the health needs of the population, especially the poor and the vulnerable segments. It is hoped that this document would be used as an instrument to invigorate public debate on health sector development and reform issues in India.

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